

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G382	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 213 N PARKER STREET 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	
W000000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of Survey: December 9, 10, 11, 12, 13, 16, and 17, 2013</p> <p>Surveyor: Kathy J. Wanner, QIDP</p> <p>Facility number: 000896 Provider number: 15G382 AIM number: 100235140</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/23/13 by Ruth Shackelford, QIDP.</p>	W000000			

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

TITLE

(X6) DATE

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

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, the facility failed to include the specific physical support/redirection technique staff were to utilize for 1 of 2 sampled clients (client #2) with a Self Management Plan (SMP).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 12/11/13 at 2:15 P.M. Client #2's record indicated he had a SMP dated 1/2013 which included the targeted behaviors of taunting, provoking, property damage, inappropriate eating, obsessive behavior, physical aggression, AWOL (absent without leave) and inactivity. Client #2's SMP included the reactive interventions of "physical support" as a last resort for physically aggressive behaviors and "physical redirection to prevent me (client #2) from harming myself," if client #2 went AWOL and put himself or someone else in direct danger. Client #2's SMP did not include a description of what physical support/physical redirections were and how they were implemented by staff.</p>	W000289	<p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual Program Plan. The Self-Management Policy that governs the management of inappropriate client behavior was revised and all QDP's were trained on this revision. (See attachment A) QDP's have been trained to include specific restraint methods/techniques in Individualized Self-Management Plans. (See attachment A) To ensure ongoing compliance, the Self-Management Policy is reviewed annually by management. All staff receive training and are required to sign off on the Self-Management Policy annually. Director, Coordinator, and QDP Responsible.</p>	01/16/2014	

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	<p>The Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed on 12/12/13 at 2:14 P.M. The QIDP stated, "Staff would physically block, remove items from area, use two staff if possible. Follow Cardinal's Procedures on self management interventions. Start with the least restrictive. I don't think we have had any episodes where he has had to be physically supported. If he had a pattern of 3 in 3 months then we would add it to his plan." The QIDPD stated, "We are in the process of adding the descriptions to everyone's SMPs, but, I guess it has not been added to his yet."</p> <p>9-3-5(a)</p>			
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W000312	<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 record review and interview for 1 of 2 sampled clients receiving medications to control behaviors (client #1), the facility failed to implement a plan of reduction the client could achieve to reduce and eventually eliminate the behaviors for which the client received psychoactive medications.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/11/13 at 1:30 P.M. Client #1's Self Management Plan (SMP) dated 2/2013 indicated client #1 had the following targeted behaviors: Hallucinations (auditory and visual), SIB/self-injurious behaviors (hitting self in face/chest with fist) and anxiety (slapping table, talking to his shirt collar, buckling/unbuckling belt, taking shoes on/off). The record review indicated client #1 received the following psychoactive medications: Aricept (Alzheimer) to stimulate brain function, Zyprexa (anti-psychotic) for schizophrenia, Risperidone (anti-psychotic) for mood stabilizing and</p>	W000312	<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 toward the reduction of and eventual elimination of the behaviors for which the drugs are employed. Self-Management Plan for client #1 was reviewed and revised as appropriate to include a plan of reduction that is attainable to reduce and eventually eliminate the behaviors for which the client receives psychoactive medication. (See attachment B) QDP's received training to incorporate attainable criteria into psychotropic medication plans of reduction for all individuals receiving psychoactive medication. (See attachment C) Support Services Coordinator will monitor through Human Rights Committee review of psychotropic medication use and the annual review of plans of reduction. Ongoing compliance will be maintained through Human Rights Review of all medications and internal file reviews annually by QDP's, Managers and Coordinator. Coordinator, QDP</p>	01/16/2014

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	<p>schizophrenia, Cogentin (anti-cholinergic) for drooling, Lorazepam (anti-anxiety) for anxiety and Propranolol (beta blocker) for tremors. Client #1's SMP indicated: "A reduction in Zyprexa may be considered at the advisement of the psychiatrist or when [client #1] has 0 SIBs and 0 Hallucinations for 12 consecutive months. A reduction in Risperdal, Ativan, Propranolol, and Cogentin may be considered at the advisement of the psychiatrist or upon successful reduction or discontinuation of Zyprexa."</p> <p>The Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed on 12/12/13 at 2:14 P.M. When asked if client #1's goals for medication reduction were attainable by client #1, the QIDPD stated, "He is contraindicated for reduction. His guardians do not want his medications reduced." When asked if client #1 had any months of 0 SIB and 0 Hallucinations, the QIDPD stated, "According to the data he had 1 month of 0 hallucinations and 2 months of no SIB that were not consecutive."</p> <p>9-3-5(a)</p>		and Manager Responsible				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility nursing services failed to develop a transfer protocol for 1 of 2 sampled clients (client #3) who required assistance with transfers to ensure the client's safety.</p> <p>Findings include:</p> <p>Facility records were reviewed on 12/10/13 at 10:10 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time frame between 12/9/12 and 12/9/13.</p> <p>A BDDS report dated 12/8/13 at 6:30 P.M. indicated: "...[client #3] was being assisted in transferring from an armed chair in his living room to his wheelchair by staff. He had all pertinent adaptive equipment in place. He was wearing shoes and staff had a hold of his gait belt during said transfer. While standing he (client #3) crossed his feet and lost his balance. He fell forward and hit his head on the entertainment center. Staff was unable to correct the fall. The initial blow pushed his helmet back and the exposed scalp just past his hairline hit the tip of the next drawer causing a shallow cut approximately a half inch in length. Staff assisted in stopping the bleeding and</p>	W000331	<p>W331The facility must provide clients with nursing services in accordancewith their needs. Nursing services will be provided inaccordance with regulations and individualized based on each person's needs.Each identified risk will be addressed as appropriate and specified in eachclient's program plan. Transfer protocol has been written for client #3based on individual need. (See attachment D) Staff will be trained on client #3 transferprotocol by January 16, 2014. Nurse and QDP were trained to provide individualizedprotocol for persons served and training to staff on implementation of suchprotocol. (See attachment E)To ensure ongoing compliance, Residential Managerwill review documentation weekly, QMRP will review documentation monthly andNurse will review documentation as per doctor's orders and monthly.Coordinator, Nurse,QMRP and Manager Responsible.</p>	01/16/2014	

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	<p>cleansing the wound. A head injury tracking sheet and an infection tracking sheet was started."</p> <p>A BDDS report dated 11/1/13 for an incident on 10/31/13 at 7:50 P.M. indicated: "...[client #3] was being assisted into bed when his socked feet slipped out from under him. He fell on his left side. He scraped his knuckles on his left hand on his bed frame. The 1/2 (one-half) inch wound was assessed and cleaned. It was covered with a standard sized bandage. All adaptive equipment was in place was being used (sic) at the time. Staff will train [client #3] on keeping his shoes on during transfers."</p> <p>A BDDS report dated 4/28/13 for an incident on 4/27/13 at 11:00 A.M. indicated: "...[client #3] attempted to transfer himself from his bed to his wheelchair without staff assistance. Staff was entering the room to check on him as he was in the process of doing this however he lost his balance and hit his head on the night stand before staff could reach him. He was not wearing his adaptive equipment even though he had access to them. He remained conscious and was assessed by staff. They noticed a cut approximately the size of a quarter....suggested he go to the emergency room (ER). At the</p>			

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	<p>ER...cleaned his wound and applied five staples to assist in closing the wound. He was released with basic head injury discharge instructions."</p> <p>A BDDS report dated 1/25/13 for an incident on 1/23/13 at 6:15 P.M. indicated: Staff assisting with transferring client #3 from wheelchair to kitchen chair with arms. Client #3's foot slipped and he fell into the chair with his weight on the left arm of the chair. The chair fell over sideways with him (client #3) in it...on 1/25/13 there was a 1 inch by 3 inch red mark on his left should consistent with the fall. Client #3 to now use wheelchair at the table for meals.</p> <p>Client #3's record was reviewed on 12/11/13 at 2:42 P.M. Client #3's record indicated he utilized a wheelchair, walker, helmet, and monitor for safety. Client #3's Individual Support Plan (ISP) dated 2/28/13 included formal goals for locking his brakes (wheelchair), wearing helmet at all waking hours, and gesturing to what he wants in his closet. Client #3 had the bar of his closet lowered to a level he could reach from his wheelchair. Client #3 had a monitor to alert staff if he tried to get out of bed independently. Client #3's record did not include a transfer protocol.</p>						

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	<p>The Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed on 12/12/13 at 2:07 P.M. When asked if client #3 had a transfer protocol, the QIDPD stated, "We just met Tuesday after this last incident. We now put in place there are to be 2 staff at all transfers. Yes, the house does have two staff working overnights." When asked if there was any documentation of staff being trained on how to do a 2 staff transfer with client #3, the QIDPD stated, "They signed off on house meeting minutes."</p> <p>The QIDPD was interviewed again on 12/16/13 at 11:55 A.M. When asked if there was a plan/protocol describing for staff how they were to transfer client #3, the QIDPD stated, "No there isn't a protocol. Yeah, that is something we could do."</p> <p>9-3-6(a)</p>						

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to administer medications to 2 of 4 sampled clients (clients #1 and #2) in accordance with their physician's orders (PO).</p> <p>Findings include:</p> <p>Facility records were reviewed on 12/10/13 at 10:10 A.M. including the Bureau of Disabilities Services (BDDS) reports for the time frame between 12/9/12 and 12/9/13.</p> <p>A BDDS report dated 8/8/13 for an incident on 7/30/13 at 11:00 A.M. indicated client #1 received 10mg (milligrams) additional Baclofen (muscle relaxant) at the day program between 7/31/13 and 8/7/13.</p> <p>Client #1's record was reviewed on 12/11/13 at 1:30 P.M. Client #1's PO dated 10/28/13 indicated client #1 was prescribed Baclofen 10mg take 1 tablet by mouth four times daily.</p> <p>The facility LPN was interviewed on 12/16/13 at 2:19 P.M. When asked if client #1 had received his medications</p>	W000368	W368 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Cardinal Services strives to provide consistent, accurate medication administration for the people that we support. To ensure that medications are administered free from error Parker Street staff received additional training outlining the proper procedures for error free medication passes and the addition of a medication pass check list in November, 2013 and again by December 31, 2013. (see attachment F) There have not been additional medication errors in the Parker St. group home since August 7, 2013. To ensure that medication errors were reduced throughout the Residential Program, all Residential staff received training regarding this additional procedure by November 9, 2013. (See attachment G) To prevent medication errors in the Work Services/Day Program areas, the medication Pass Check List was implemented in these locations and training was provided to all staff by January 6, 2014. (See Attachment H) To prevent this deficiency in the future, the Residential Manager, QDP,	01/16/2014			

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	<p>correctly, the LPN stated, "I am not sure the information on the BDDS report was accurate. He (client #1) was at home with his parents some of those days. When I look at the MAR (medication administration record) and his attendance record I believe he received the 20mg Baclofen instead of the 10mg Baclofen on two days in error here at the day program 8/5/13 and 8/6/13. His parents had the doctor increase the dosage to 20mg at his appointment on 7/30/13 and then had the doctor change it back to the original 10mg dose. The parents returned the 20mg card to the day program without telling anyone the dosage had been changed back to the original dose of 10mg. I believe I have things worked out with mom now, so she will involve me in any and all medical changes."</p> <p>A BDDS report dated 4/26/13 for an incident on 4/25/13 at 6:00 A.M. indicated: "...[client #2] received 4mg of Risperidone (anti-psychotic) on 4/25/13 instead of the prescribed 3mg Risperidone daily...."</p> <p>A BDDS report dated 3/8/13 for an incident on 3/7/13 at 6:30 A.M. indicated: "On 3/7/13 [client #2] received 3mg Risperidone instead of the 1mg that was prescribed by the doctor...."</p>		<p>Nurse, Residential Coordinator, Adult Day Services supervisor staff and the Adult Services Coordinator will monitor the administration of medications through weekly, monthly and quarterly unannounced observations in the group home. In addition, the Adult Day Services Coordinator and supervisory staff will increase observations in the Day Services location to three times weekly until competency can be demonstrated. Residential Manager, QDP, Nurse and Residential Coordinator and Adult Day Services Coordinator responsible.</p>				

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	<p>Client #2's record was reviewed on 12/11/13 at 2:15 P.M. Client #2's PO dated 10/27/13 indicated client #2 was prescribed Risperidone 1mg take 1 tablet by mouth every morning and Risperidone 2mg take 1 tablet by mouth every evening.</p> <p>The facility LPN was interviewed on 12/16/13 at 2:19 P.M. When asked if client #2 had received his medications correctly, the LPN stated, "Not according to the MAR (medication administration record) or the physician's orders."</p> <p>9-3-6(a)</p>			

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W000426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review and interview, the facility failed to ensure 4 of 4 sampled clients (clients #1, #2, #3 and #4) who were not able to regulate water temperature were not exposed to water exceeding 110 degrees Fahrenheit.</p> <p>Findings include:</p> <p>Water temperature readings at the group home were conducted on 12/10/13 at 5:37 P.M. The water temperature in the shower on the right side of the duplex designed home registered 118.2 degrees Fahrenheit. The Water temperature at the kitchen sink on the right side of the duplex designed home registered 120.5 degrees Fahrenheit.</p> <p>Direct Care Staff (DCS) #5 was interviewed on 12/10/13 at 5:47 P.M. DCS #5 stated, "Yes, we do have two water heaters, one for each side of the house. I think night shift checks the temperature of the water. The clients do need assistance with water."</p> <p>DCS #7 was interviewed on 12/10/13 at</p>	W000426	<p>W 426 The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Cardinal Services takes our responsibility to ensure for the safety of those we support seriously. On December 10, 2013 when the water temperature reading was out of the accepted range staff immediately contacted the emergency Maintenance pager and submitted a Maintenance Request with a "Critical" urgency noted as per standard procedure. (See Attachment I)The on call maintenance personnel came to the home and found that the highest water temperature reading they could get was 104 degrees. A water temperature tracking was implemented on December 13, 2013 with staff checking the water temperature in the home twice daily to ensure water temperatures were within the safe range. As of January 8, 2014, the highest reading has been 109.8 degrees. (See Attachment J) To ensure for the</p>	01/16/2014	

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	<p>5:50 P.M. DCS #7 stated, "No, the clients can not mix water independently."</p> <p>Client #1's record was reviewed on 12/11/13 at 1:30 P.M. Client #1's record included a Risk Assessment Summary dated 2/28/13 which indicated: "Yes, I am at risk for water temperatures. I have an anti-scalding device in my home."</p> <p>Client #2's record was reviewed on 12/11/13 at 2:15 P.M. Client #2's record included a Risk Assessment Summary dated 1/24/13 which indicated: "Yes, I am at risk for water temperatures. Water temperatures do not exceed 110."</p> <p>Client #3's record was reviewed on 12/11/13 at 2:42 P.M. Client #3's record included a Risk Assessment Summary dated 2/28/13 which indicated: "Yes, I am at risk for water temperatures. I have an anti-scalding device in my home."</p> <p>Client #4's record was reviewed on 12/11/13 at 3:12 P.M. Client #4's record included a Risk Assessment Summary dated 7/10/13 which indicated: "Yes, I am at risk for water temperatures. I have an anti-scalding device in my home."</p> <p>The Residential Manager (RM) was interviewed on 12/12/13 at 1:12 P.M. The RM stated, "Supposed to be between 100</p>		<p>safety of the men living in the home, staff will continue to monitor water temperatures twice daily in the home for 90 days to ensure that water temperatures are consistent and that the men are not at risk of scalding. At the end of the 90 day tracking period staff will complete daily water temperature checks and document the results. (See Attachment K) To ensure water temperature safety throughout the Residential Program, daily water temperature checks will be implemented in all Residential locations on January 16, 2014 (See Attachment L) To assure that water temperatures remain at safe levels in all group homes Residential Managers, Residential Coordinators and the Maintenance department will also continue to perform monthly and quarterly water temperature checks in addition to the daily checks.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G382	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
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	and 110. They do monthly checks and I do quarterly checks, so I am not sure why it was high. I know most of the clients in the home can not mix water safely. There is a regulator on the water heaters." 9-3-7(a)			