

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 2/20, 2/24, 2/25, 2/26, 2/27, 2/28 and 3/6, 2014.</p> <p>Facility number: 003172 Provider number: 15G695 AIM number: 200361630</p> <p>Surveyors: Amber Bloss, QIDP-TC Paula Chika, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/17/14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
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 observation, record review, and interview, the facility failed to implement the facility's policy on neglect to prevent recurrent pressure ulcers for 1 of 4 sampled clients (#3) and to investigate a pattern of injuries of unknown origin for 1 additional client (#5).</p> <p>Findings include:</p> <p>1) On 2/24/14 between 4:35 PM and 6:15 PM, group home observations were conducted. At 4:35 PM, Client #3 was seated in a standard (no gravity tilt feature) wheelchair with use of a chest halter and lap belt. At 5:09 PM, Client #3 continued to be seated in his wheelchair in the living area with his body posture leaning forward. At 5:25 PM, DSP (Direct Support Professional) #2 wheeled Client #3 to the other side of the duplex-style living area to get barbeque sauce for dinner. Between 5:31 PM and 6:15 PM, dinner was served. Throughout the dinner observation, Client #3 remained seated in his wheelchair in front of the television which was on. Throughout the evening observation, Client #3 remained seated in his wheelchair with the chest strap secured with a forward leaning body position. Client #3 was not assisted in repositioning or moved to another chair, mat, or wedge. Client #3 was not observed to reposition himself independently.</p> <p>On 2/20/14 at 1:05 PM and on 2/26/14 at 10:53 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/01/13 to 2/26/14 were reviewed. A BDDS report dated</p>	W000149	<p>W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility will ensure that the established policy and procedure is implemented to prohibit mistreatment, abuse or neglect. Staff will be trained on this policy by 4/5/14. Staff were trained on client #3 Repositioning/documentation and skin assessment/documentation on 3/26/14. (see attachment A) Client #3 new Wheelchair was ordered on 3/12/14. (see attachment B) Residential staff, managers and QDPs were trained on proper investigation protocol for injuries of unknown origin on 3/13/14 (see attachment C) Client #5 IDT met on 3/25/14 to analyze the pattern of injuries and determine action steps. (see attachment D) To ensure systemic compliance across the agency, all Residential Managers and Residential Shift Managers received training on 3/14/14, 3/15/14 and 3/17/14 to review all tracking sheets daily/weekly as assigned. (see attachment E) To ensure ongoing compliance</p>	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>9/23/13 indicated "on September 20, 2013 [Client #3] was seen at [urgent care] at 12:30 PM due to cough/congestion and pink unopened sores on his buttocks. After being assessed by the attending physician it was determined that [Client #3] has Bronchitis. The doctor felt the pink unopened sores were not compromised at this time." The BDDS report indicated "the doctor discontinued the use of the adaptive donut cushion that [Client #3] sits on while in his wheelchair and to monitor the area on his buttocks."</p> <p>-The follow up BDDS report dated 9/27/13 indicated "the unopened sores were diagnosed as cellulitis when he saw his PCP (primary care physician) on 8/20/13. [Client #3] uses [brand] skin repair cream at each brief change to treat this condition."</p> <p>A BDDS report dated 10/11/13 indicated "during a nursing assessment on [Client #3]'s buttocks the residential nurse noted a 1 cm (centimeter) in diameter area that was slightly opened with minimal bleeding. Noted to be from shearing due to repositioning."</p> <p>-A follow up BDDS report dated 10/11/13 indicated Client #3 "is capable of moving to reposition himself but drags his bottom rather than picking it up when moving. This causes friction and has caused this subsequent 'shearing' when he repositions himself. The Nurse states that per her assessment she views this as a decubitus ulcer from shearing. The nurse requested an order for Mepilex (foam wound dressing) to treat the area and implemented a skin integrity care plan for [Client #3]."</p> <p>-A follow up BDDS report dated 10/25/13 indicated "the original stage of the ulcer was a Stage 2." The report indicated Client #3 "does</p>		<p>with repositioning, skinassessment, investigation of injuries, etc. Shift Managers will monitor each shift, Residential Manager will monitor daily, Nurse will monitor weekly, QDP will monitor monthly and Coordinator will monitor quarterly. Quality Assessment Analysis Team will monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors and Nurses. QMRP, Residential Manager, Nurse, Coordinator and Director Responsible.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>not have a history of pressure ulcers and therefore uses a standard mattress at this time." The report indicated Client #3 does not use positioning aids as he can reposition himself.</p> <p>A BDDS report dated 12/12/13 indicated "on 12/11/13 at approximately 2:00 PM it was noted [Client #3] had an area of skin breakdown on his left buttocks. The area was generally rectangular in shape and measured about 1 cm (centimeter) across. The residential nurse assessed the area and recommended that staff utilize his PRN (use as needed) mepilex (foam wound dressing) and complete skin assessments twice daily. [Client #3] has a recent history of skin breakdown with one other incident noted on October 11, 2013. [Client #3] has a care plan for skin integrity and a repositioning schedule. Staff was following this schedule and care plan."</p> <p>-A follow up BDDS report dated 12/19/13 indicated "the ulcer was assessed as a stage 1 ulcer." The report indicated Client #3 was incontinent and "is also wheelchair bound and had a G-Tube (gastronomy tube) placed this year which has increased the amount of time that he spends sitting up after eating." The report indicated "a PT (physical therapy) evaluation was completed in November 2013 with a recommendation for a new wheelchair."</p> <p>-A follow up BDDS report dated 12/26/13 indicated "the area is healed."</p> <p>On 2/26/14 at 11:26 AM, record review indicated Client #3's ISP (Individual Support Plan) dated 4/25/13 indicated Client #3 used "a wheelchair with seatbelt & chest strap to assist me in sitting upright." Client #3's ISP indicated he utilized his "wheelchair during all waking hours unless I choose to sit in (a) recliner." The ISP meeting</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>notes also dated 4/25/13 indicated "the team discussed [Client #3]'s posture in his wheelchair. [QIDP (Qualified Intellectual Disabilities Professional)] shared that they could look into a chair that tilts. She stated they have been getting good results from [Wheelchair Provider]." The meeting notes indicated "[the guardian] stated he is all for seeing what we can do to make him more comfortable." Record review indicated Client #3 had received a "wheelchair evaluation" on 11/20/13. Record review indicated no documentation available to indicate Client #3's new wheelchair had been ordered.</p> <p>Record review indicated Client #3 had a care plan for "risk for skin integrity" dated 10/15/13. The care plan indicated the following "planning and implementations:"</p> <p>"a. Staff will implement positioning schedule in which [Client #3] will reposition at least every two hours even when in his wheelchair, staff will track on tracking sheet reflecting position change every two hours.</p> <p>b. [Client #3] has an order from the PCP (primary care physician) that he must sit up for 90 minutes after meals and meds, staff will reposition him after 45 minutes.</p> <p>c. When [Client #3] is in the RR (rest room) staff will check on him at least every 15 minutes to prevent shearing D/T (due to) client is able to reposition self on toilet.</p> <p>d. When [Client #3] is in bed staff will make sure that his bottom is well protected with his brief that skin is not accessible to shearing when [Client #3] moves on the sheet. Staff will check this every two hours during bed checks.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>e. The nurse will assess any areas of concerns at least weekly.</p> <p>f. The nurse will review position tracking monthly to ensure compliance.</p> <p>g. Staff will implement and follow any orders from physician or nursing without fail.</p> <p>h. Staff will complete a daily skin assessment and track any changes noted. Staff will report any increase in size, shape, color, depth (of skin area of concern) by the end of the shift it was noted.</p> <p>i. [Client #3]'s brief is to be checked every two hours, more frequently when determined medically necessary."</p> <p>Record review indicated Client #3 had a "Position Tracking Sheet" only for 2/2014. The chart had 12 boxes, 1 box to be initialed for each 2 hour period in a 24 hour day. The following indicated how many position changes were not initialed as having been completed:</p> <p>2/1/14- 8 of 12 missing 2/2/14- 8 of 12 missing 2/3/14- 4 of 12 missing 2/4/14- 3 of 12 missing 2/5/14- 4 of 12 missing 2/6/14- 7 of 12 missing 2/7/14- 5 of 12 missing 2/8/14- 8 of 12 missing 2/9/14- 12 of 12 missing 2/14/14- 5 of 12 missing 2/15/14- 12 of 12 missing 2/16/14- 12 of 12 missing 2/17/14- 3 of 12 missing 2/18/14- 3 of 12 missing 2/19/14- 3 of 12 missing 2/20/14- 3 of 12 missing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>2/21/14- 4 of 12 missing 2/22/14- 12 of 12 missing 2/23/14- 12 of 12 missing 2/27/14- 4 of 12 missing</p> <p>Record review indicated no further documentation available for review of monthly tracking for repositioning of Client #3 since his skin integrity plan was implemented on 10/15/13.</p> <p>On 2/24/14 at 11:53 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated he did not know whether Client #3's new wheelchair had been ordered.</p> <p>On 2/27/14 at 12:45 PM during an interview, the Nurse indicated staff are to follow the skin care integrity plan to prevent and monitor for signs or symptoms of pressure ulcers for Client #3. The Nurse indicated she didn't know whether Client #3's new wheelchair had been ordered.</p> <p>On 2/28/14 at 11:15 AM during an interview, the Residential Coordinator (RC) indicated Client #3's wheelchair had not been ordered. The RC indicated the original fax may have gotten misplaced. The RC indicated the facility would request the wheelchair provider to reissue it to the facility to order Client #3's wheelchair. The RC indicated staff should have been repositioning Client #3 every two hours as indicated in his skin integrity plan. The RC indicated there was no further documentation for review regarding Client #3's repositioning tracking.</p> <p>On 2/26/14 at 11:58 AM, the facility policy on "Incident/Abuse/Neglect Policy of Persons Served" dated 5/13 was reviewed. The policy indicated the facility was "committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
--------------------	--	---------------	---	----------------------

	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 as outlined in this policy." The facility abuse and neglect policy defined neglect as "incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support, including food, drink, clothing, shelter, sleep, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities)."			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
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>2) The facility's reportable incident reports, Accident/Injury Reports (AIRs) and/or investigations were reviewed on 2/26/14 at 2:04 PM. The facility's reportable incident reports, AIRs and/or investigations indicated the following injuries of unknown source for client #5:</p> <p>a. 8/19/13 "On Monday August 19, 2013 at approximately 9:30 am the Residential Manager (RM) was informed that [client #5's] right index finger was discolored and (sic) swollen. The Residential Nurse was contacted, completed an assessment of the injury and requested an order for an X-ray from [client #5's] primary care physician to assess for injury. At (sic) approximately 4:00 pm the order for (sic) the X-ray had been received so the Nurse advised staff to take [client #5] to [name of medical facility], a local urgent care facility, for (sic) evaluation. An X-ray was taken and showed a fracture of the right index finger. The on-call physician recommended that [client #5] see an orthopedic physician to follow up with his injury. [Client #5] was seen by the physician on Tuesday August 20, 2013 (sic) at 1:00pm. She (sic) stated that the fracture was stable, but due (sic) to [client #5's] potential to attempt to remove the splint, a (sic) cast was applied (sic). It was noted that [client #5's] middle right finger was also swollen and slightly bruised and there was bruising in the palm area of [client #5's] right hand. The physician stated that this was consistent with an injury that occurred 'a few days ago.' [Client #5] has an appointment for cast removal with [name of doctor] on September 9, 2013. An immediate</p>	W000149	<p>W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility will ensure that the established policy and procedure is implemented to prohibit mistreatment, abuse or neglect. Staff will be trained on this policy by 4/5/14. Staff were trained on client #3 Repositioning/documentation and skin assessment/documentation on 3/26/14. (see attachment A) Client #3 new Wheelchair was ordered on 3/12/14. (see attachment B) Residential staff, managers and QDPs were trained on proper investigation protocol for injuries of unknown origin on 3/13/14 (see attachment C) Client #5 IDT met on 3/25/14 to analyze the pattern of injuries and determine action steps. (see attachment D) To ensure systemic compliance across the agency, all Residential Managers and Residential Shift Managers received training on 3/14/14, 3/15/14 and 3/17/14 to review all tracking sheets daily/weekly as assigned. (see attachment E) To ensure ongoing compliance</p>	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>investigation was begun to determine the origin of the injury and at this time is currently ongoing. To ensure for [client #5's] immediate safety, staff (sic) has been instructed to provide one-on-one supervision (one staff to one client) for [client #5] and monitor his activity (sic) during all waking hours. [Client #5] (sic) mat (sic) spend time by himself in his bedroom and will be allowed privacy while in the bathroom. During (sic) these times staff must check on his well being every 10 minutes. Third shift staff must complete 30 minute bed checks to ensure for [client #5's] safety. At this time it is not suspected that staff is involved in the origin of this injury. As per policy and procedure regarding patients seen in the ER (emergency room) who are under a specific age or non-verbal, [name of medical facility] (sic) contacted the [name of city police] police department. [Name of policeman] has questioned the staff that assisted [client #5] during the appointment, the (sic) Residential Manager and the staff that found the injury. At this time a police report is not available. The Residential Manager will continue the investigation to determine the most probable cause of this injury. To ensure for (sic) his safety and to prevent additional injuries, staff will continue to follow the one-on-one level of supervision...."</p> <p>The facility's 8/24/13 investigation indicated facility staff thought client #5 could have hit his hand on his wooden frame of his bed. The facility's investigation indicated facility staff did not see client #5 do anything that would cause injury to the client's hand. The investigation indicated facility staff were interviewed. The facility's investigation indicated the following (not all inclusive):</p> <p>-PM Shift Manager undated summary indicated client #5's bed frame was made of wood and the</p>		<p>with repositioning, skin assessment, investigation of injuries, etc. Shift Managers will monitor each shift, Residential Manager will monitor daily, Nurse will monitor weekly, QDP will monitor monthly and Coordinator will monitor quarterly. Quality Assessment Analysis Team will monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors and Nurses. QMRP, Residential Manager, Nurse, Coordinator and Director Responsible.</p>	
--	---	--	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>client could have hit his hand on the frame while sleeping.</p> <p>-Weekend shift manager undated summary indicated she assisted the client to get ready for bed on 8/18/13 and client #5 did not have any injuries to his hand before he went to bed.</p> <p>-Staff #3's undated summary indicated he did not hear anything from client #5's bedroom on the night shift of 8/18/13. The undated summary indicated "...[client #5] will become restless while he sleeps and that [client #5] may have hit his wooden bed frame with his hand either during his sleep or when he was waking up and waiting for staff to come and assist him."</p> <p>-Staff #4's undated summary indicated staff #5 did not notice any injuries to client #5's hands when she assisted the client to get up and ready on 8/18/13. Staff #4's summary indicated "...[client #5] often sits on the toilet with his finger (sic) curled around the grab bars or in his wheel chair with his fingers curled around the seat...[Staff #4] said that she thought the bruising might have been from when [client #5] sits in his wheelchair with his fingers curled around the edge of the seat. She stated the (sic) he often pushes himself up while holding on to the chair and this would cause pressure. [Staff #4] also stated that [client #5] is often fairly careless as he moves through his house is will 'crash into' furniture, door frames, etc. and this may have caused the fracture. All staff stated that they did not harm [client #5] and did not see a staff person or person served do anything that could have caused [client #5's] injury...."</p> <p>The facility's 8/24/13 investigation indicated "...Progress Notes and Communication book did not have any documentation regarding the origin</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>of this injury. [Client #5's] 90-day Physician order shows that [client #5] has a diagnosis of Osteoporosis and takes medication for this. This can cause [client #5's] bones to be at risk for fracture...Conclusion:...After interviewing all staff that worked with [client #5] this investigation concludes that the most probable cause of [client #5's] fracture is incidental contact with his wooden bed frame or possibly from running into furniture or doorways while in his wheelchair. There is no evidence to substantiate abuse or neglect. Outcome:...Staff will provide [client #5] with one-on-one supervision during all waking hours with the exception of times that [client #5] chooses to relax in his bedroom. To ensure for his safety during these times if [client #5] is awake, staff will complete 10 minutes (sic) checks and if he is asleep staff will complete 30 minute checks. The IDT (interdisciplinary team) will consider the purchase of a low bed without wooden frame. In the interim, the bed frame will be padded."</p> <p>b. On 11/10/13, "While dressing [client #5] today for a shower I noticed a 1.6cm (centimeter) and a 0.4mm (millimeter) scratch and 0.4mm scratch on the back right side of [client #5's] neck. The area resembles scratch marks from [client #5's] fingernails when [client #5] attempts to take his helmet off. [Client #5's] nails are not long and are well filed and I do not see that this could have been prevented. [Client #5] does not like to wear his helmet at all times and is very quick at taking his helmet off." The 11/10/13 AIR did not indicate/include any additional documentation of interviews and/or investigation in regard to the client's injury of unknown source as the client's nails were "well filed."</p> <p>c. On 1/3/14, "At 6:00 am when [client #5] was getting up for his day staff noticed a dime sized</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>cut that had happened in his sleep during the night. The cut looks as if it were from scratching at his head. When staff checked his nails they had been filed down prior to the accident. Staff does not know how this was avoidable, due to his nails already been trimmed (sic). Staff will be sure to keep up on trimming of the nails and keep an eye out for contact with his head." The 1/3/14 AIR (Accident/Injury Report) did not indicate any additional information and/or investigation in regard to the client's injury of unknown source. The 1/3/14 AIR did not indicate/include documentation of any interviews with staff and/or clients.</p> <p>Client #5's record was reviewed on 2/28/14 at 11:23 AM. Client #5's 9/16/13 Self Management Plan (SMP) indicated "I (client #5) no longer require one on one staffing in my home or in the community. My staff is strongly encouraged to use one on one for a CBI (Community Based Integration) to reinforce my good behavior but I can go out with the group as well. The staffing ratio 1:3 (one to three) applies in the community as well in the home. I need to stay in my side of the home because of conflict with one of my peers who lives on the opposite side of the home...." Client #5's 9/16/13 SMP did not indicate client #5's IDT met to review client #5's pattern of injuries of unknown source to determine how client #5 was actually injuring himself and/or being injured.</p> <p>Interview with the RC, LPN #1, and the Qualified Intellectual Disabilities Professional (QIDP) on 2/27/14 at 11:44 AM indicated it was not determined how client #5 fractured his finger. The RC and the QIDP indicated the client's IDT had not met to review the client's recent injuries of unknown source/pattern. The QIDP and RC indicated client #5 utilized a wheelchair for</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>mobility. The RC, LPN #1 and the QIDP indicated they were in the process of looking for a nursing home placement for client #5.</p> <p>Interview with the RC on 2/26/14 at 3:38 PM indicated the facility had recently started a new investigative procedure for injuries of unknown source. Administrative staff #1 indicated the facility was not using the new form/procedure when the 11/10/13 injury occurred but it should have been used for client #5's 1/3/14 injury of unknown origin.</p> <p>On 2/26/14 at 11:58 AM, the facility policy on "Incident/Abuse/Neglect Policy of Persons Served" dated 5/13 was reviewed. The policy indicated the facility was "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 as outlined in this policy." The facility abuse and neglect policy defined neglect as "incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support, including food, drink, clothing, shelter, sleep, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities)."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate client to client abuse for 1 of 1 incident of client to client abuse for 1 of 4 sampled clients (#4) and 1 additional client (#6).</p> <p>Based on interview and record review for 3 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed for clients #3 and #5, the facility failed to ensure it conducted thorough investigations in regard to the allegations of neglect and/or injuries of unknown source.</p> <p>Findings include:</p> <p>1) On 2/20/14 at 1:05 PM and on 2/26/14 at 10:53 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/01/13 to 2/26/14 were reviewed. A BDDS report dated 9/14/13 indicated "at approximately 7:50 AM, [Client #6] attempted to cause injury to a peer (Client #4) with his hands. The other consumer (Client #4) defended himself and [Client #6] sustained superficial injuries to below his eye on the right side, and above his left eyebrow. Both areas hold scratches; .5 cm (centimeter) in length, and two scratches 5 cm and 1 cm respectively." The report indicated Client #6 "will be counseled, and a closer eye will be kept to ensure both men are safe." The 9/14/13 BDDS report did not indicate any additional documentation or an investigation.</p> <p>A BDDS report also dated 9/14/13 indicated "at approximately 7:50 AM on 9/14/13 [Client #4]</p>	W000154	W154The facility must have evidence that all alleged violationsare thoroughly investigated. The facility will implement thorough investigation protocolper investigation training. ResidentialManagers and QDPs were trained on thorough investigation procedures for injury of unobserved origin on March 13,2014. (see attachment F) Direct Support Professionals and QDPs received training on 3/17/14to report all instances of client to client abuse. (see attachment G) Staff were trained on proper investigation protocol forinjuries of unknown origin on 3/13/14. (see attachment C) Client #5 IDT met on 3/25/14 to analyze the pattern ofinjuries and determine action steps. (see attachment D) To ensure systemic compliance across the agency, allResidential Managers received training to investigate thoroughly all instancesof client to client abuse and injuries of unknown origin. (see attachment H)To ensure ongoing compliance Shift Managers will submitappropriate accident/incident reports daily as needed, Residential Manager willmonitor and investigate daily as needed. Residential Coordinator will monitor all	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>was sitting in his chair watching morning television. [Client #4] was attacked by another peer and received superficial injuries to the top right of his head, below his right eye, and the left side of his nose. Each area holds a scratch; 1.5 cm (centimeters) in length, 1 cm in length, .5 cm in length respectively." The 9/14/13 BDDS report did not indicate any additional documentation or an investigation.</p> <p>During an interview on 2/24/14 at 1:54 PM, the Residential Coordinator (RC) indicated there was no investigation completed in regards to the client to client abuse which occurred on 9/14/13. The RC stated "we thought if staff witnessed the client to client abuse, it didn't need to be investigated."</p>		<p>accident/injury reports in addition to BDDS incident reports in order to assure that all investigations are thorough and timely. Quality Assessment Analysis Team will monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors and Nurses. Residential Manager, Coordinator and Director Responsible.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>2) The facility's reportable incident reports, Accident/Injury Reports (AIRs) and/or investigations were reviewed on 2/26/14 at 2:04 PM. The facility's 10/9/13 AIR indicated "On 10/9/13 at approximately 12:30 PM staff observed that [client #3] had a small abrasion on the left side of his buttocks. It appears to have been caused by friction during repositioning. Staff informed the RM (Residential Manager) and the residential nurse immediately. The residential nurse assessed the area a short time later and was in agreement with the cause of the injury. The residential nurse instructed staff to apply his PRN (as needed) topical and gauze and to also complete an accident /injury report. This injury was not preventable. [Client #3] is capable of shifting his weight/repositioning himself to a point." The 10/9/13 AIR indicated the following:</p> <p>-No "environmental hazard" contributed to client #3's injury. -Safety equipment was provided. -Safety equipment was in use at the time of the injury.</p> <p>The facility's AIR did not indicate any additional information, interviews and/or investigation in regard to how client #3 received the friction/pressure area from repositioning.</p> <p>Interview with the Residential Coordinator (RC) on 2/28/14 at 2:57 PM indicated there was no additional documentation and/or investigation to review in regard to client #3's injury of unknown source/allegation of neglect.</p>	W000154	<p>W154The facility must have evidence that all alleged violationsare thoroughly investigated. The facility will implement thorough investigation protocolper investigation training. ResidentialManagers and QDPs were trained on thorough investigation procedures for injury of unobserved origin on March 13,2014. (see attachment F) Direct Support Professionals and QDPs received training on 3/17/14to report all instances of client to client abuse. (see attachment G) Staff were trained on proper investigation protocol forinjuries of unknown origin on 3/13/14. (see attachment C) Client #5 IDT met on 3/25/14 to analyze the pattern ofinjuries and determine action steps. (see attachment D) To ensure systemic compliance across the agency, allResidential Managers received training to investigate thoroughly all instancesof client to client abuse and injuries of unknown origin. (see attachment H)To ensure ongoing compliance Shift Managers will submitappropriate accident/incident reports daily as needed, Residential Manager willmonitor and investigate daily as needed. Residential Coordinator will monitor all</p>	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>3) The facility's reportable incident reports, Accident/Injury Reports (AIRs) and/or investigations were reviewed on 2/26/14 at 2:04 PM. The facility's AIRs indicated the following:</p> <p>-1/3/14 "At 6:00 am when [client #5] was getting up for his day staff noticed a dime sized cut that had happened in his sleep during the night. The cut looks as if it were from scratching at his head. When staff checked his nails they had been filed down prior to the accident. Staff does not know how this was avoidable, due to his nails already been trimmed (sic). Staff will be sure to keep up on trimming of the nails and keep an eye out for contact with his head." The 1/3/14 AIR did not indicate any additional information and/or investigation in regard to the client's injury of unknown source. The 1/3/14 AIR did not indicate/include documentation of any interviews with staff and/or clients.</p> <p>-11/10/13 "While dressing [client #5] today for a shower I noticed a 1.6cm (centimeter) and a 0.4mm (millimeter) scratch a 0.4mm scratch on the back right side of [client #5's] neck. The area resembles scratch marks from [client #5's] fingernails when [client #5] attempts to take his helmet off. [Client #5's] nails are not long and are well filed and I do not see that this could have been prevented. [Client #5's] does not like to wear his helmet at all times and is very quick at taking his helmet off." The 11/10/13 AIR did not indicate/include any additional documentation of interviews and/or investigation in regard to the client's injury of unknown source as the client's nails were "well filed."</p> <p>Interview with the RC on 2/26/14 at 3:38 PM indicated the facility had recently started a new investigative procedure for injuries of unknown</p>		<p>accident/injury reports in addition to BDDS incident reports in order to assure that all investigations are thorough and timely. Quality Assessment Analysis Team will monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors and Nurses. Residential Manager, Coordinator and Director Responsible.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>source. Administrative staff #1 indicated the facility was not using the new form/procedure when the 11/10/13 injury occurred but it should have been used for client #5's 1/3/14 injury of unknown origin.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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, interview and record review for 1 of 4 sampled clients (#2), the client's Person Centered Plan (PCP) failed to address the client's identified behavioral needs in regard to masturbation and self injurious behavior of digging in anus.</p> <p>Findings include:</p> <p>On 2/24/14 between 4:35 PM and 6:15 PM, group home observations were conducted. At 4:35 PM, Client #2 was seated in the recliner rocking. At 5:34 PM, Client #2 was seated in a fetal position in the recliner rocking. Between 5:31 PM and 5:58 PM, dinner was served. At 6:08 PM, Client #2 was seated on the recliner with his hand down his pants visibly masturbating while in the common living area.</p> <p>Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's 12/6/13 Medical Summary Progress Report indicated client #2 was having "forceful masturbation."</p> <p>Client #2's October 2013 typed Nurse Notes indicated on 10/7/13, "Staff called and stated client has been tugging on penis extremely hard...."</p> <p>Client #2's 12/6/13 Intervention Strategies</p>	W000227	<p>W227The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. The facility has revised the self-management plan for client#2 on 3/11/14. (See attachment M) The Residential Manager and Direct Support Professionals were trained on this plan on 3/26/14. (see attachment M) A tracking has been implemented to monitor when client #2 is compelled to place his fingers and hand in his rectum. (see attachment M) Direct Support Professionals were trained on the tracking on 3/26/14. (see attachment M) To ensure ongoing compliance with plan implementation, Shift Managers will monitor trackingsheets for each shift, Residential Manager will monitor each day, QDP each week and Coordinator will monitor quarterly.</p>	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>indicated client #2 demonstrated self abusive behavior defined as "I may push very hard on my jaw with my hand...." Client #2's intervention plan and/or 12/6/13 PCP did not indicate the client's identified behavior of masturbating and/or masturbating in public had been addressed.</p> <p>Interview with the Residential Coordinator on 2/28/14 at 2:57 PM indicated client #2 did not have an objective/program which addressed the client's identified behavioral need in regard to masturbation.</p> <p>2. Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's Physical Assessment Tools indicated the following:</p> <p>-1/13/14 client #2 had a "(red area above crack)" which facility staff placed Vaseline (petroleum ointment) on.</p> <p>-10/1/13 "Vaseline (PRN) (as needed) sore on butt crack."</p> <p>-9/2/13 Client #2 had "sore above crack." The note indicated Vaseline was applied to the area.</p> <p>-8/2/13 Client #2 had a red area on "top crack" of his buttock which staff placed Vaseline on.</p> <p>Client #2's typed October 2013 nurse notes indicated the following:</p> <p>-On 10/7/13, client #2 was "...digging in his anus...."</p> <p>-10/31/13 "...and a sore on the top of butt crack that is monitored and has PRN Vaseline applied for barrier."</p> <p>-9/30/13 "A Physical Assessment was completed</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>today...Areas of concern noted are Vaseline used to abrasion above crack on buttocks,...."</p> <p>Client #2's 12/16/13 PCP and/or 12/6/13 Intervention Strategies indicated client #2's identified behavior of digging in his anus had not been addressed.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/27/14 at 1:20 PM indicated client #2 did not have problems with pressure areas. QIDP #1 stated client #2's above mentioned areas on the client's buttocks occurred from "Digging." The QIDP indicated client #2 was seeing a psychiatrist on 2/27/14 due to the client's behavior. The QIDP indicated client #2's PCP and/or intervention strategy did not address the client's identified behavioral need.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#2), the client's Person Centered Plans (PCPs) failed to indicate when and/or how facility staff were to use the client's gait belt.</p> <p>Findings include:</p> <p>During the observation on 2/24/14 between 4:35 PM and 6:15 PM, at the group home, client #2 was blind in that the client could not see. During the observation periods, client #2 wore a gait belt which facility staff did not use and/or encourage the client to use when ambulating around the group home.</p> <p>Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's 2/4/14 physician orders indicated "Wear gait belt while ambulating PRN (as needed)." Client #2's 12/6/13 PCP indicated client #2's diagnoses included, but were not limited to, Blind and Congenital Anomaly of the eye.</p> <p>Client #2's 12/6/13 PCP did not specifically indicate when client #2 was to wear his gait belt and/or indicate how/when facility staff were to use the client's gait belt.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and LPN #1 on 2/27/14 at 1:20 PM indicated client #2 was blind. The QIDP indicated client #2 would refuse to use a cane when going out into the community. The QIDP indicated facility staff were to use a gait</p>	W000240	<p>W240The individual program plan must describe relevant interventions to support the individual toward independence. QDP's were trained on development of individual program plans to include relevant interventions that support individuals toward independence on 3/28/14. (see attachment I) Client #2 Mobility Screening and Fall Risk Plan was revised on 3/1/14. (see attachment J) Staff were trained on the revised plan on 3/26/14. (see attachment J) To ensure ongoing compliance with gait belt use, Shift Managers will monitor each shift, Residential Manager will monitor daily, QDP will monitor weekly and Coordinator will monitor quarterly. Shift Manager, Residential Manager, QMRP, and Coordinator responsible.</p>	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
--------------------	--	---------------	---	----------------------

	belt to assist client #2 with ambulating when going out into the community. The QIDP indicated client #2's PCP did not specifically indicate when/how facility staff were to use a gait belt with client #2. 9-3-4(a)			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
--------------------	--	---------------	---	----------------------

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, the facility staff failed to follow a client's fall risk plan during van loading which resulted in a fall for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 2/24/14 between 4:35 PM and 6:15 PM, group home observations were conducted. At 4:35 PM, Client #1 had his jacket around his waist as he had taken the sleeves off but the button and/or zipper was still secured around the bottom of the coat. At 4:55 PM, Client #1 had put his coat back on and a gait belt was also secured around his waist. Throughout the observation, Client #1 ambulated independently and would move from the lounge chair where he would look out the window to walking in the living area. Client #1 wore the gait belt throughout the observation. No staff utilized Client #1's gait belt during observation.</p> <p>On 2/25/14 between 6:15 AM and 9:24 AM, group home observations were conducted. At 6:23 AM, Client #1 was ambulating in the living area. During an interview at 6:47 AM, the House Manager (HM) stated Client #1 was a "fall risk" because "he has an issue of walking on his toes and walks quickly." The HM stated Client #1 "wants to run outdoors, he wants to go, he can trip on the door frame because he is unsteady."</p>	W000249	<p>W249As 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. Client #1 Fall Risk Plan will be reviewed and revised as needed by April 5, 2014. Staff will receive training on revised plan by April 5, 2014. To ensure ongoing implementation of client #1 Fall Risk Plan, Shift Managers will monitor each shift, Residential Manager will monitor daily, QDP will monitor weekly and Coordinator will monitor quarterly. Shift Manager, Residential Manager, QMRP, and Coordinator responsible.</p>	04/05/2014
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>Between 7:16 AM and 7:30 AM, Client #1 ate breakfast. Client #1 was wearing the gait belt. At 7:55 AM, Client #1 was seated in the lounge chair in the living area. At 8:00 AM, a couple of clients got ready to be transported to day program. At 8:11 AM, Client #1 was pacing around the living area quickly. At 8:20 AM, Client #1 lost his balance and fell. No staff was within arms length of the client and no use of gaitbelt was observed before Client #1 fell. Client #1 landed on his left hip with both feet elevated. DSP (Direct Support Professional) #4 lifted Client #1 back to a standing position by use of his gait belt. DSP #4 held Client #1's gait belt and assisted him to the lounge chair. DSP #4 pushed up Client #1's sleeve and checked his right elbow for injury.</p> <p>On 2/28/14 at 2:15 PM, record review indicated Client #1 had a "Mobility Screening & Fall Risk Plan" dated 12/6/13. Client #1's fall risk plan indicated "I am able to walk independently but require staff to be within arm's length or close by of me in normal settings when I am walking. Staff should be within arms length of me in community settings. Staff will ask me to slow down and walk carefully when I am walking on uneven surfaces, changing surfaces, getting up from seated position or bending over and use my gait belt as needed." The fall plan indicated an additional revision on 3/6/13 which indicated "due to a recent injury that occurred while peers were loading the bus the following will be implemented: When the bus is being loading (sic) with peers, staff will keep me within eyesight and within a distance to intervene if necessary. I have a history of bolting towards the van and it has resulted in injury. Staff needs to assist me to stay safe during this period of time...." The risk plan indicated "because I am often unsteady when I first rise, staff must be sure to be close to assist me using the gait belt as I stand and when I am attempting to reach the van</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>or bus first for outings or when I am exiting the bus to get back into the home."</p> <p>During an interview on 2/25/14 at 2:05 PM in reference to Client #1's fall on 2/25/14 at 8:20 AM, the Residential Coordinator (RC) stated the House Manager (HM) "said it was not a fall." The RC stated the HM "did not see it as a fall and he (Client #1) just sat down and was going to talk to staff." The RC indicated the HM "should have written an 'Injury and Accident' report." The RC indicated they believed the staff had followed Client #1's fall risk plan. The RC stated DSP #4 indicated Client #1 did not fall but rather did a "spin" followed by a "hard sit." The RC indicated Client #1 has a history of falls during morning hours during the loading of the transportation van.</p> <p>9-3-4(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on 1 of 1 sampled client with a restrictive program (#2), the facility's Human Rights Committee (HRS) failed to review and/or approve the use of a sleep/behavioral medication to ensure the rights of the client were protected.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's 2/4/14 physician's orders indicated client #2 received Melatonin (sleep) 3 milligrams by mouth at bedtime.</p> <p>Client #2's 12/6/13 Person Centered Plan (PCP) and/or 12/6/13 Intervention Strategies did not indicate the facility's HRC monitored, reviewed and/or approved the use of the Melatonin for sleep for client #2.</p> <p>Interview with LPN #1, the QIDP and the Residential Coordinator (RC) on 2/27/14 at 1:20 PM indicated client #2 received the Melatonin for sleep. The QIDP indicated the facility's HRC had not reviewed and/or approved the use of the restrictive program/Melatonin.</p> <p>9-3-4(a)</p>	W000262	W262 The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that in the opinion of the committee, involve risks to client protection and rights. The facility revised the Intervention Strategies for client #2 to include the use of Melatonin 3mg on 3/11/14. (see attachment N) The QDP obtained Human Rights Committee approval for the use of melatonin on 3/12/14. (see attachment O) The QDPS received additional training on Human Rights Committee approvals on 3/27/14. (see attachment O) To ensure ongoing compliance, this will be monitored by the coordinator through bimonthly Human Rights Committee meetings.	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
--------------------	--	---------------	---	----------------------

W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 1 of 1 sampled client with a restrictive program (client #2), who had a legal guardian, the facility failed to obtain written informed consent for the use of the sleep aid/restrictive program.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's 2/4/14 physician's orders indicated client #2 received Melatonin (sleep) 3 milligrams by mouth at bedtime.</p> <p>Client #2's 2/14 Sleep Tracking chart indicated the facility tracked/monitored client #2's sleep.</p> <p>Client #2's 12/6/13 Person Centered Plan (PCP) and/or 12/6/13 Intervention Strategies indicated client #2 had a legal guardian. Client #2's PCP and/or intervention strategy did not indicate client #2's guardian gave written informed consent for the use of the restrictive Melatonin/program.</p> <p>Interview with LPN #1, the QIDP and the Residential Coordinator (RC) on 2/27/14 at 1:20 PM indicated client #2 received the Melatonin for sleep. The QIDP indicated the client had a guardian. When asked if client #2's guardian gave written informed consent for the restrictive program/use, the QIDP did not provide any documentation the client's guardian gave written informed consent for its use.</p>	W000263	<p>W263The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. The QDP obtained Guardian approval for the use of Melatonin on 3/12/14. (see attachment O) The QDP obtained Human Rights Committee approval for the use of melatonin on 3/12/14. (see attachment O) The QDPS received additional training on obtaining Guardian approvals for all psych medications on 3/27/14. (see attachment O) To ensure ongoing compliance, this will be monitored by the Support Services Coordinator through bimonthly Human Rights Committee meetings.</p>	04/05/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
	9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
--------------------	--	---------------	---	----------------------

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.</p> <p>Based on interview and record review for 1 of 1 sampled client with behavior controlling medication (client #2), the facility failed to develop an active treatment program which included how/when the facility would consider a reduction in the medication for the behavior for which the medication was prescribed.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's 2/4/14 physician's orders indicated client #2 received Melatonin (sleep) 3 milligrams by mouth at bedtime.</p> <p>Client #2's 2/14 Sleep Tracking chart indicated the facility tracked/monitored client #2's sleep.</p> <p>Client #2's 6/17/13 Record Of Drug Regimen Review (pharmacy reviews) indicated "...Client will see psychiatrist 'prn' (as needed). Melatonin to be followed by PCP (primary care physician)."</p> <p>Client #2's 12/6/13 Person Centered Plan (PCP) and/or 12/6/13 Intervention Strategies did not indicate client #2 had an active treatment program for sleep (lack of sleep). Client #2's PCP and/or intervention strategies did not indicate a plan of reduction had been put in place based on the behaviors for which the client had received the Melatonin.</p>	W000312	<p>W312Drugs 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. Client #2 Intervention Strategies were reviewed and revised as appropriate to include a plan of reduction for all psychotropic medications. (See attachment N) QDPs were trained on including reduction plans on 3/27/14. (see attachment N) Support Services Coordinator will monitor through Human Rights Committee review of psychotropic medication use. Ongoing compliance will be maintained through Human Rights Review of all medications.</p>	04/05/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>Interview with LPN #1, the QIDP and the Residential Coordinator (RC) on 2/27/14 at 1:20 PM indicated client #2 received the Melatonin for sleep. LPN #1 indicated client #2's psychiatrist indicated client #2's primary care doctor could monitor the use of the Melatonin. The QIDP indicated client #2 was seeing a psychiatrist on 2/27/14. The QIDP indicated client #2 did not have an active treatment program for sleep/the use of the Melatonin, and/or a plan of reduction based on the behaviors for which the client received the medication.</p> <p>9-3-5(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility nurse failed to develop care plans to monitor for signs and symptoms of Atelectasis (condition of complete or partial collapse of a lung) in regards to monitoring weight weekly, assessing for pain, shortness of breath, and edema of the legs or feet for 1 additional client reviewed for Atelectasis (#5).</p> <p>Based on record review and interview, the facility nurse failed to ensure a repositioning schedule was implemented and monitored for 1 of 1 sampled client reviewed with recurrent pressure ulcers (#3).</p> <p>Based on observation, interviews and record review for 2 of 3 sampled clients (#2 and #4), the facility's nursing services failed to obtain clarification of client #2's diet orders, to develop a risk plan for client #2's chronic Urinary Tract Infections (UTIs), to ensure a recommendation for specific scans/tests was completed for client #2, and to develop a risk plan for the use and monitoring of client #4's Warfarin (anticoagulant-blood thinner).</p> <p>Findings include:</p> <p>1) On 2/20/14 at 1:05 PM and on 2/26/14 at 10:53 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/01/13 to 2/26/14 were reviewed. A BDDS report dated 11/12/13 indicated on "November 11, 2013 staff took [Client #5] to [hospital] per instructions of the Residential Nurse due to [Client #5] having an elevated pulse rate and</p>	W000331	W331The facility must provide clients with nursing services in accordance with their needs. Nursing services will be provided in accordance with client needs as specified in each client's program plans, risk plans and health care plans. Specific and sufficient health care services will be provided through the implementation of client specific protocols for identified areas of risk. The facility nurse was trained to provide nursing services in accordance with client need on 3/26/14. (see attachment P) A care plan for Client #5 for Atelectasis was developed on 3/26/14. (see attachment Q) Direct Support Professionals were trained on the care plan for client #5 on 3/26/14. (see attachment Q) A repositioning tracking sheet for client #3 was implemented and Direct Support Professionals were trained on 3/26/14. (see attachment A) A skin assessment tracking for client #3 was implemented on 3/26/14. (see attachment A) Direct Support Professionals were trained on the skin assessment on 3/26/14. (see attachment A) The care plan for client #2 's frequent UTIs was revised on 3/24/14. (see attachment R) A Coumadin tracking for client #4 was created	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>excessive coughing through the evening. Once there labs and a chest x-ray were ordered. Results of the lab work completed there showed that he has Aspiration Pneumonia. [Client #5] was admitted into [hospital] for treatment at 10:00 AM." The report indicated the nurse updated Client #5's pneumonia care plan.</p> <p>-A follow up BDDS report indicated "[Client #5] was released from the [hospital] on November 14, 2013 with a diagnosis of a partial atelectasis (collapsed lung)." The report indicated the hospital physician "stated that this will be a chronic condition that staff was not able to prevent and that [Client #5] will require intermittent hospitalization to treat this condition." The report indicated to "ensure for [Client #5]'s well-being his Nurse provided training to staff regarding this condition and the monitoring that they will be responsible to complete." The report indicated "staff is required to weigh [Client #5] every Friday and watch for weight gain of more than five pounds each week. In addition staff will monitor [Client #5] daily for pain, elevated temperature, edema and shortness of breath and report concerns immediately to the Nurse."</p> <p>On 2/28/14 at 11:23 PM, record review indicated Client #5's diagnoses included, but were not limited to, profound mental retardation, duodenal ulcer, osteoporosis, constipation and hiatal hernia. Record review indicated Client #5 had a pneumonia care plan dated 9/27/13 which included the following interventions:</p> <p>"a. Staff will continue to elevate HOB (head of bed) to a 30 degree angle to ensure the diaphragm is lowered and promoting chest expansion.</p> <p>b. Nurse will auscultate lung fields (listen for internal sounds) noting areas decrease/absent</p>		<p>andimplemented on 3/17/14. Direct Support professionals were trained on it on 3/26/14.(see attachment S) A Doctor order was obtained for the puree diet with Nectarthickened liquids to correspond with the dietician recommendations. (seeattachment T) To ensure ongoing compliance, Shift Managers will monitoreach shift, Residential Manager will monitor daily, Nurse will monitor weekly,QDP will monitor monthly and Coordinator will monitor quarterly. Quality Assessment Analysis Team will monitormonthly for trends. Quality Assessment Analysis Team includes Coordinators,Directors and Nurses.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>airflow...</p> <p>c. Staff will take client's temperature daily to monitor for any infection.</p> <p>d. Client will ambulate around the house twice a day to help with fatigue and respirations.</p> <p>e. When client is coughing staff will offer warm liquids instead of cold to mobilize and remove secretions.</p> <p>f. Staff will administer Mucinex DM (expectorant and cough suppressant) as needed to assist with coughing and aid in bronchospasm and mobilizations of secretions.</p> <p>g. 10/16/13 revised: [Client #5] is to be on puree diet along with Honey thickened liquids...</p> <p>h. 11/11/13 revised: [Client #5] is to only have 4 oz of liquids Honey Thickened at one time...."</p> <p>Record review indicated a staff training dated 11/15/13 regarding Client #5's diagnosis of Atelectasis (partial lung collapse). The training indicated Atelectasis was defined as "a complete or partial collapse of a lung or lobe of a lung - develops when the tiny air sacs (alveoli) within the lung become deflated." The training indicated "Atelectasis is also a possible complication of other respiratory problems, including cystic fibrosis, inhaled foreign objects, lung tumors, fluid in the lung, severe asthma and chest injuries." The training indicated "Atelectasis can be serious because it reduces the amount of oxygen available to your body." The training indicated "discharge orders are to contact [hospital doctor] for:</p> <p>*weight gain of more than 5 pounds in a week.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>Staff will need to weigh every Friday. *fever greater than 101. Staff are to take temperature daily. *new onset or change in pain. Staff to assess daily. *new onset or change in severity of shortness of breath. If really struggling to breathe call 911. *new onset or change in swelling of legs or feet. Staff to assess daily."</p> <p>Record review indicated nurses notes from 10/1/13 to 12/31/13. A nurses note dated 10/2/13 indicated Client #5 was "seen in the ER (emergency room) D/T (due to) client is very fatigued, will not stand for staff, it takes at least three staff to get client out of bed. Client is having a hard time breathing." The nurses notes indicated Client #5 was diagnosed with aspiration pneumonia and was admitted into the hospital from 10/2/13 to 10/6/13. A nurses note dated 10/16/13 indicated Client #5 "was admitted to [hospital] with DX (diagnosis) of aspiration pneumonia." Nurses notes indicated Client #5 was discharged from the hospital on 10/19/13. A nurse note dated 11/11/13 indicated Client #5 "was admitted to [hospital] with a DX (diagnosis) of aspiration pneumonia." Nurses notes indicated Client #5 was discharged from the hospital on 11/14/13. Nurses note dated 11/21/13 indicated Client #5 had a follow up with the physician. The physician "states client's atelectasis is not life threatening. [Physician] also stated the atelectasis means it is an area of the lung that is over stretched and it may look on an X-ray like pneumonia but it is not. [Physician] stated aspiration pneumonia is likely to recur even if a feeding tube is placed in the stomach, client will need to go the ER (emergency room) only for fever, cough, decline in health."</p> <p>Record review indicated Client #5 was weighed</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>on 11/30/13 and on 12/31/13. Record review indicated Client #5 had his temperature checked daily in the month of February 2014. There was no further documentation for weekly weights, monitoring for edema, shortness of breath, or assessments for pain as associated with Client #5's diagnosis of atelectasis.</p> <p>On 2/28/14 at 1:07 PM during an interview, the Nurse stated Client #5 had not been weighed weekly as the doctor ordered "due to weather." The Nurse stated "she didn't want to put clients at risk" of pneumonia by "letting clients" go outside to have been weighed at the facility. The Nurse indicated there was no monitoring of signs of symptoms of atelectasis in regards to pain, edema, and shortness of breath.</p> <p>On 2/28/14 at 2:23 PM, the Residential Coordinator (RC) indicated there was no further documentation to indicate Client #5 had been weighed weekly. The RC stated there was no documentation to indicate staff were monitoring Client #5's shortness of breath, pain assessment, and signs of edema in the legs and feet but "there should be."</p> <p>2) On 2/24/14 between 4:35 PM and 6:15 PM, group home observations were conducted. At 4:35 PM, Client #3 was seated in a standard (no gravity tilt feature) wheelchair with use of a chest halter and lap belt. At 5:09 PM, Client #3 continued to be seated in his wheelchair in the living area with his body posture leaning forward. Between 5:31 PM and 6:15 PM, dinner was served. Throughout the dinner observation, Client #3 remained seated in his wheelchair in front of the television which was on. Throughout the evening observation, Client #3 remained seated in his wheelchair with the chest strap secured with a forward leaning body position. Throughout the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>observation, Client #3 was not observed to be assisted in repositioning or moved to another chair, mat, or wedge. Client #3 was not observed to reposition himself independently.</p> <p>On 2/20/14 at 1:05 PM and on 2/26/14 at 10:53 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/01/13 to 2/26/14 were reviewed. A BDDS report dated 9/23/13 indicated "on September 20, 2013 [Client #3] was seen at [urgent care] at 12:30 PM due to cough/congestion and pink unopened sores on his buttocks. After being assessed by the attending physician it was determined that [Client #3] has Bronchitis. The doctor felt the pink unopened sores were not compromised at this time." The BDDS report indicated "the doctor discontinued the use of the adaptive donut cushion that [Client #3] sits on while in his wheelchair and to monitor the area on his buttocks."</p> <p>-The follow up BDDS report dated 9/27/13 indicated "the unopened sores were diagnosed as cellulitis when he saw his PCP (primary care physician) on 8/20/13. [Client #3] uses [brand] skin repair cream at each brief change to treat this condition."</p> <p>A BDDS report dated 10/11/13 indicated "during a nursing assessment on [Client #3]'s buttocks the residential nurse noted a 1 cm (centimeter) in diameter area that was slightly opened with minimal bleeding. Noted to be from shearing due to repositioning."</p> <p>-A follow up BDDS report dated 10/11/13 indicated Client #3 "is capable of moving to reposition himself but drags his bottom rather than picking it up when moving. This causes friction and has caused this subsequent 'shearing' when her repositions himself. The Nurse states that per her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>assessment she views this as a decubitus ulcer from shearing. The nurse requested an order for Mepilex (foam wound dressing) to treat the area and implemented a skin integrity care plan for [Client #3]."</p> <p>-A follow up BDDS report dated 10/25/13 indicated "the original stage of the ulcer was a Stage 3." The report indicated Client #3 "does not have a history of pressure ulcers and therefore uses a standard mattress at this time." The report indicated Client #3 does not use positioning aids as he can reposition himself.</p> <p>A BDDS report dated 12/12/13 indicated "on 12/11/13 at approximately 2:00 PM it was noted [Client #3] had an area of skin breakdown on his left buttocks. The area was generally rectangular in shape and measured about 1 cm (centimeters) across. The residential nurse assessed the area and recommended that staff utilize his PRN (use as needed) mepilex (foam wound dressing) and complete skin assessments twice daily. [Client #3] has a recent history of skin breakdown with one other incident noted on October 11, 2013. [Client #3] has a care plan for skin integrity and a repositioning schedule. Staff was following this schedule and care plan."</p> <p>-A follow up BDDS report dated 12/19/13 indicated "the ulcer was assessed as a stage 1 ulcer." The report indicated Client #3 was incontinent and "is also wheelchair bound and had a G-Tube (gastronomy tube) placed this year which has increased the amount of time that he spends sitting up after eating." The report indicated a PT (physical therapy) evaluation was completed "in November 2013 with a recommendation for a new wheelchair."</p> <p>-A follow up BDDS report dated 12/26/13</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>indicated "the area is healed."</p> <p>On 2/26/14 at 11:26 AM, record review indicated Client #3's ISP (Individual Support Plan) dated 4/25/13 indicated Client #3 used "a wheelchair with seatbelt & chest strap to assist me in sitting upright." Client #3's ISP indicated he utilized his "wheelchair during all waking hours unless I choose to sit in (a) recliner." The ISP meeting notes also dated 4/25/13 indicated "the team discussed [Client #3]'s posture in his wheelchair. [QIDP (Qualified Intellectual Disabilities Professional)] shared that they could look into a chair that tilts. She stated they have been getting good results from [Wheelchair Provider]." The meeting notes indicated "[the guardian] stated he is all for seeing what we can do to make him more comfortable." Record review indicated a "Medical Summary Progress Report" dated 11/20/13 which indicated Client #3 had received a physical therapy evaluation which indicated a recommendation of "w/c (wheelchair) eval. (evaluation). Record review indicated the facility nursing services failed to monitor/ensure Client #3's wheelchair had been ordered.</p> <p>Record review indicated Client #3 had a care plan for "risk for skin integrity" dated 10/15/13. The care indicated the following "planning and implementations:"</p> <p>"a. Staff will implement positioning schedule in which [Client #3] will reposition at least every two hours even when in his wheelchair, staff will track on tracking sheet reflecting position change every two hours.</p> <p>b. [Client #3] has an order from the PCP (primary care physician) that he must sit up for 90 minutes after meals and meds, staff will reposition him after 45 minutes.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>c. When [Client #3] is in the RR (rest room) staff will check on him at least every 15 minutes to prevent shearing D/T (due to) client is able to reposition self on toilet.</p> <p>d. When [Client #3] is in bed staff will make sure that his bottom is well protected with his brief that skin is not accessible to shearing when [Client #3] moves on the sheet. Staff will check this every two hours during bed checks.</p> <p>e. The nurse will assess any areas of concerns at least weekly.</p> <p>f. The nurse will review position tracking monthly to ensure compliance.</p> <p>g. Staff will implement and follow any orders from physician or nursing without fail.</p> <p>h. Staff will complete a daily skin assessment and track any changes noted. Staff will report any increase in size, shape, color, depth by the end of the shift it was noted.</p> <p>i. [Client #3]'s brief is to be checked every two hours, more frequently when determined medically necessary."</p> <p>Record review indicated Client #3 had a "Position Tracking Sheet" only for 2/2014. The chart had 12 boxes, 1 box to be initialed for each 2 hour period in a 24 hour day. The following indicated how many position changes were not initialed as having been completed:</p> <p>2/1/14- 8 of 12 missing 2/2/14- 8 of 12 missing 2/3/14- 4 of 12 missing 2/4/14- 3 of 12 missing</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>2/5/14- 4 of 12 missing 2/6/14- 7 of 12 missing 2/7/14- 5 of 12 missing 2/8/14- 8 of 12 missing 2/9/14- 12 of 12 missing 2/14/14- 5 of 12 missing 2/15/14- 12 of 12 missing 2/16/14- 12 of 12 missing 2/17/14- 3 of 12 missing 2/18/14- 3 of 12 missing 2/19/14- 3 of 12 missing 2/20/14- 3 of 12 missing 2/21/14- 4 of 12 missing 2/22/14- 12 of 12 missing 2/23/14- 12 of 12 missing 2/27/14- 4 of 12 missing</p> <p>Record review indicated no further documentation available for review of monthly tracking for repositioning of Client #3 since his skin integrity plan was implemented on 10/15/13.</p> <p>On 2/24/14 at 11:53 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated he did not know whether Client #3's new wheelchair had been ordered.</p> <p>On 2/27/14 at 12:45 PM during an interview, the Nurse indicated staff are to follow the skin care integrity plan to prevent and monitor for signs or symptoms of pressure ulcers for Client #3. The Nurse indicated she didn't know whether Client #3's new wheelchair had been ordered. The Nurse indicated she was to monitor Client #3's repositioning schedule on a monthly basis.</p> <p>On 2/28/14 at 11:15 AM during an interview, the Residential Coordinator (RC) indicated Client #3's wheelchair had not been ordered. The RC indicated the original fax may have gotten misplaced. The RC indicated the facility would</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
	request the wheelchair provider reissue it to the facility to order Client #3's wheelchair. The RC indicated staff should have been repositioning Client #3 every two hours as indicated in his skin integrity plan. The RC indicated was no further documentation for review regarding Client #3's repositioning tracking. The RC indicated the facility nurse was to monitor Client #3's repositioning tracking each month as indicated in Client #3's skin integrity plan.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>3) Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's 9/25/13 Medical Summary Progress Report indicated a swallow study was completed on client #2. The summary note indicated "NPO (nothing by mouth) recommended due to silent aspiration." The swallow study indicated client #2 was "not functional/not safe for oral intake."</p> <p>Client #2's 12/6/13 Person Centered Plan (PCP) indicated client #2 received a Mechanical soft diet with food cut into bite size pieces.</p> <p>Client #2's Medical Progress Notes (nursing notes) indicated the following (not all inclusive):</p> <p>-9/17/13 Client #2 was diagnosed with UTI and possible aspiration. The note indicated client #2's doctor ordered a swallow study be completed.</p> <p>-9/25/13 Client #2 had the recommended swallow study. The note indicated client #2 was a silent aspirator on pureed textures. The note indicated "...client aspirated and did not clear large amount of pudding x (times) 2, speech therapist recommends client to be NPO..."</p> <p>-9/26/13 Client #2's IDT (interdisciplinary team) would discuss what would be best for the client as the client enjoyed eating.</p> <p>-9/30/13 Client #2's guardian was aware of the speech therapist recommendations.</p> <p>-10/3/13 "Client's guardian called and talked about pros and cons of client getting a G-Tube</p>	W000331	<p>W331The facility must provide clients with nursing services inaccordance with their needs. Nursing services will be provided in accordance with clientneeds as specified in each client's program plans, risk plans and health careplans. Specific and sufficient health care services will beprovided through the implementation of client specific protocols for identifiedareas of risk. The facility nurse was trained to provide nursing servicesin accordance with client need on 3/267/14. (see attachment P) A care plan for Client #5 for Atelectasis was developed on 3/26/14.(see attachment Q) Direct Support Professionals were trained on the care planfor client #5 on 3/26/14. (see attachment Q) A repositioning tracking sheet for client #3 was implementedand Direct Support Professionals were trained on 3/26/14. (see attachment A) A skin assessment tracking for client #3 was implemented on3/26/14. (see attachment A) Direct Support Professionals were trained on the skin assessmenton 3/26/14. (see attachment A) The care plan for client #2 's frequent UTIs was revised on 3/24/14.(see attachment R) A Coumadin tracking for client #4 was created</p>	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>(gastronomy feeding tube) D/T (due to) client having a swallow study completed on 9/25. Guardian does not want client to have G-Tube. guardian (sic) has a phone conference with [name of doctor] at 2 PM today to discuss options."</p> <p>-10/3/13 Client #2's guardian spoke with the client's doctor. The note indicated the client's guardian and doctor agreed client #2 should not have a G-Tube. The note indicated "...Orders are to follow aspiration precautions."</p> <p>-11/5/13 "Staff reported that client was coughing while drinking his liquids during meals today. Writer (LPN #1) sent nursing order for nectar thickened liquids to be used as a trial period. Writer also informed [name of doctor]."</p> <p>-11/5/13 "[Name of doctor] agreed with nectar thickened liquids."</p> <p>-11/30/13 "...Client started on Nectar liquids D/T (due to) coughing with liquids."</p> <p>Client #2's 1/12/14 Nutritional Assessment indicated client #2 received a pureed diet with Nectar thickened liquids.</p> <p>Client #2's 10/15/13 risk plan for aspiration indicated client #2 was on a pureed diet with thin liquids.</p> <p>Client #2's 2/4/14 physician's orders indicated "DIET: PUREED DIET DUE TO REGURGITATION;..." The diet order did not specify the type of liquid texture client #2 was to receive.</p> <p>Interview with LPN #1 on 2/27/14 at 1:20 PM when asked what kind of diet client #2 received, LPN #1 stated "pureed." When asked what</p>		<p>andimplemented on 3/17/14. Direct Support professionals were trained on it on 3/26/14.(see attachment S) A Doctor order was obtained for the puree diet with Nectarthickened liquids to correspond with the dietician recommendations. (seeattachment T) To ensure ongoing compliance, Shift Managers will monitoreach shift, Residential Manager will monitor daily, Nurse will monitor weekly,QDP will monitor monthly and Coordinator will monitor quarterly. Quality Assessment Analysis Team will monitormonthly for trends. Quality Assessment Analysis Team includes Coordinators,Directors and Nurses.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>texture of liquid client #2 received, LPN #1 stated "Not sure with liquid."</p> <p>Interview with LPN #1 on 2/28/14 at 11:50 AM indicated client #2 was to receive a pureed diet with nectar thick liquids. LPN #1 client #2's 10/15/13 aspiration risk plan indicated client #2 was to receive thin liquids. LPN #1 indicated as of 2/28/14, she updated the risk plan to say pureed diet with nectar thickened liquids.</p> <p>4. Client #2's record was reviewed on 2/27/14 at 10:17 AM. Client #2's 12/16/13 Medical Summary Progress Report indicated client #2 saw his primary care doctor in regard to a "Strong smelling urine, some blood in urine a few days ago,...UTI/Hematuria (blood in urine) Recent & (and) Ecoli. We will (check) a renal/Bladder U/S (ultrasound) repeat cx (culture), start Bactrim (antibiotic) pending...."</p> <p>Client #2's 12/9/13 doctor's order indicated client #2's doctor discontinued the Bactrim and ordered Macrobid 100 milligrams twice a day for 7 days for the client's UTI. Client #2's Procedure Order sheet indicated client #2 was scheduled for a bladder ultrasound and Renal Ultrasound on 12/10/13 to arrive at 12:30 PM. The procedure order indicated a residual urine test would also be attempted at that time. Client #2's record did not indicate the above ordered tests had been completed as ordered.</p> <p>Client #2's 9/17/13 Clinical Summary report indicated client #2 saw the doctor for urinary symptoms and was diagnosed with a UTI. The summary sheet indicated client #2 was placed on Sulfamethoxazole TMP DS (antibiotic) 800-160 milligrams twice daily.</p> <p>Client #2's typed nursing notes indicated the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>following (Not all inclusive):</p> <p>-9/17/13 Client #2 was diagnosed with a UTI.</p> <p>-10/7/13 "Staff called and stated client has been tugging on penis extremely hard and digging in anus. Writer informed staff that it has been over a year since the client has seen [name of urologist] that staff needs to make an appt (appointment) with him."</p> <p>-10/8/13 "An appt was completed today with [name of urologist] D/T (due to) client having constant foul odor to urine. Order received, U/A (urinalysis) with C&S (culture & sensitivity).</p> <p>-10/29/13 "Staff reported that client has a foul odor to urine and is shredding his brief again. Writer requested and (sic) U/A with C&S if indicated. Request granted."</p> <p>Client #2's 12/6/13 Person Centered Plan indicated the client did not have a risk plan in place to prevent recurrent UTIs.</p> <p>Interview with LPN #1 on 1:20 PM on 2/27/14 indicated client #2 had a history of UTI. LPN #1 indicated client #2 did not have a risk plan for UTI. LPN #1 indicated client #2 saw a urologist due to his problems with UTIs. When asked if client #2 had a renal and bladder ultrasound, LPN #1 stated "No. Dr. decided not to do it." LPN #1 indicated she would have to check for the order to discontinue the orders for the scans/ultrasound. LPN #1 did not provide an order which discontinued the ordered scans/test.</p> <p>5. The facility's reportable incident reports, Accident/Injury Reports (AIRs) and/or investigations were reviewed on 2/26/14 at 2:04 PM. The facility's 2/22/14 reportable incident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>report indicated "On Saturday 2/22/14 [client #4] was given an additional 1/2 dose of his Warfarin (anticoagulant-blood thinner) medication. He receives this medication in pill form daily and a separate 1/2 pill dose of the same medication is also given on Mondays and Thursdays. Staff gave him the additional 1/2 pill at the Saturday evening med pass. The nurse was called immediately upon discovery. Residential nurse asked staff to watch for signs of side effects. There were no side effects observed...." An attached 2/24/14 fax by the facility's nurse to client #4's doctor indicated client #4 received Warfarin 1 milligram on Monday and Tuesday Warfarin and 2 milligrams on the other days of the week. The 2/24/14 fax indicated "...The on call nurse had all extra vitamin K foods held, had staff monitor bleeding, and client was not shaved. There were no noted side effects...."</p> <p>Client #4's record was reviewed on 2/28/14 at 11:20 AM. Client #4's 2/17/14 physician's orders indicated client #4 was to receive Warfarin 1 milligram on Tuesday and Thursday and 2 milligrams on Monday, Wednesday, Friday, Saturday and Sunday. The client's record indicated client #4 was going to a "Coumadin Clinic" where the client's Warfarin labs and bleeding times were being monitored.</p> <p>Client #4's 7/30/13 PCP indicated client #4 did not have a risk plan which addressed the use of the Warfarin, bleeding/bruising which could occur with the client, and/or when to call the nurse if client #4 received a cut/injury.</p> <p>Interview with LPN #1 on 2/28/14 at 11:50 AM indicated client #4 went to the Coumadin Clinic for the use of the Warfarin. LPN #1 indicated facility staff monitored the client for bleeding and bruising. LPN #1 indicated client #4 did not have</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
	a risk plan in place to address the use of the Warfarin. LPN #1 stated "in process of putting something in place." 9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
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 on interview and record review for 1 of 4 sampled clients (#4), the facility failed to ensure the client received a significant medication without error.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Accident/Injury Reports (AIRs) and/or investigations were reviewed on 2/26/14 at 2:04 PM. The facility's 2/22/14 reportable incident report indicated "On Saturday 2/22/14 [client #4] was given an additional 1/2 dose of his Warfarin (anticoagulant-blood thinner) medication. He receives this medication in pill form daily and a separate 1/2 pill dose of the same medication is also given on Mondays and Thursdays. Staff gave him the additional 1/2 pill at the Saturday evening med pass. The nurse was called immediately upon discovery. Residential nurse asked staff to watch for signs of side effects. There were no side effects observed...." An attached 2/24/14 fax by the facility's nurse to client #4's doctor indicated client #4 received Warfarin 1 milligram on Monday and Tuesday Warfarin and 2 milligrams on the other days of the week. The 2/24/14 fax indicated "...The on call nurse had all extra vitamin K foods held, had staff monitor bleeding, and client was not shaved. There were no noted side effects...."</p> <p>Client #4's record was reviewed on 2/28/14 at 11:20 AM. Client #4's 2/17/14 physician's orders indicated client #2 was to receive Warfarin 1 milligram on Tuesday and Thursday and 2</p>	W000368	<p>W368The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. The facility will ensure that medications are administered without error through the implement of established medication protocol. Residential staff were trained on proper medication administration on 3/14/14. (see attachment L) To ensure systemic compliance across the agency, all Direct Support Professionals will be required to pass the Medication Error Competency Test at 100% proficiency by April 5, 2014. (see attachment L) To ensure ongoing compliance with error free medication administration, the Residential Manager will monitor daily, Nurse will monitor weekly, and Coordinator will monitor quarterly. Quality Assessment Analysis Team will monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors and Nurses. Residential Manager, Nurse, Coordinator and Director Responsible.</p>	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>milligrams on Monday, Wednesday, Friday, Saturday and Sunday.</p> <p>Interview with the Residential Coordinator (RC), the Qualified Intellectual Disabilities Professional and LPN #1 on 2/27/14 at 11:44 AM indicated client #4 received extra Warfarin on 2/22/14. LPN #1 indicated the client's doctor was contacted in regard to the error and did not indicate client #4 would have any problems due to the error.</p> <p>9-3-6(a)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on interview and record review for 1 of 2 sampled clients (#3), with wheelchairs, the facility failed to order a client's new wheelchair as needed.</p> <p>Findings include:</p> <p>On 2/24/14 between 4:35 PM and 6:15 PM, group home observations were conducted. At 4:35 PM, Client #3 was seated in a standard (no gravity tilt feature) wheelchair with secured use of a chest halter and lap belt. Between 5:31 PM and 6:15 PM, dinner was served. Throughout the dinner observation, Client #3 remained seated in his wheelchair in front of the television which was turned on. Throughout the evening observation, Client #3 remained seated in his wheelchair with the chest strap secured with a forward leaning body position. Throughout the observation, Client #3 was not observed to be assisted in repositioning nor moved to another chair, floor mat, or wedge. Client #3 was not observed to reposition himself independently.</p> <p>On 2/26/14 at 11:26 AM, record review indicated Client #3's ISP (Individual Support Plan) dated 4/25/13 indicated meeting notes also dated</p>	W000436	<p>W436The facility must furnish, maintain in good repair, andteach clients to use and to make informed choices about the use of dentures,eyeglasses, hearing and other communication aids, braces, and other devicesidentified by the interdisciplinary team as needed by the client. Cardinal Services takes seriously the maintenance and use ofall adaptive equipment needed by the client. To ensure timely provision of needed equipment, QDP's, Nurses and staffwere trained on 3/27/14. (see attachment Y) Client #3 wheelchair was ordered on 3/12/14. (see attachment B) To ensure ongoing compliance with maintenance and use of alladaptive equipment, Residential Managers will monitor availability and upkeep weekly,Nurse will monitor Monthly, QDP will monitor monthly via observations andCoordinator will monitor quarterly. QMRP, Residential Manager, Nurse, and Coordinator.</p>	04/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>4/25/13 which indicated "the team discussed [Client #3]'s posture in his wheelchair. [QIDP (Qualified Intellectual Disabilities Professional)] shared that they could look into a chair that tilts. She stated they have been getting good results from [Wheelchair Provider]." The meeting notes indicated "[the guardian] stated he is all for seeing what we can do to make him more comfortable." Record review indicated a "Medical Summary Progress Report" dated 11/20/13 which indicated Client #3 had received a physical therapy evaluation with recommended a "w/c (wheelchair) eval. (evaluation.) Record review indicated no documentation available to indicated Client #3's new wheelchair had been ordered.</p> <p>On 2/20/14 at 1:05 PM and on 2/26/14 at 10:53 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/01/13 to 2/26/14 were reviewed. A BDDS report dated 12/12/13 indicated "on 12/11/13 at approximately 2:00 PM it was noted [Client #3] had an area of skin breakdown on his left buttocks. The area was generally rectangular in shape and measured about 1 cm (centimeters) across." The report indicated "[Client #3] has a recent history of skin breakdown with one other incident noted on October 11, 2013."</p> <p>-A follow up BDDS report dated 12/19/13 indicated "the ulcer was assessed as a stage 1 ulcer." The report indicated "a PT (physical therapy) evaluation was completed in November 2013 with a recommendation for a new wheelchair."</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>On 2/24/14 at 11:53 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated he did not know whether Client #3's new wheelchair had been ordered.</p> <p>On 2/27/14 at 12:45 PM during an interview, the Nurse indicated she didn't know whether Client #3's new wheelchair had been ordered.</p> <p>On 2/28/14 at 11:15 AM during an interview, the Residential Coordinator (RC) indicated Client #3's wheelchair had not been ordered. The RC indicated the original fax may have gotten misplaced. The RC indicated they requested the wheelchair provider to reissue the quote from the 11/20/13 to the facility so they could proceed to order Client #3's new wheelchair.</p> <p>9-3-7(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview the facility failed to ensure its third shift evacuation drills were conducted on a quarterly basis for 4 of 4 sampled clients and 3 additional clients (Clients #1, #2, #3, #4, #5, #6, #7).</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 2/25/14 at 8:30 AM. Documentation was present verifying drills were conducted on the night shift during the time period of one year from 2/25/13 to 2/25/14. The following 3rd shift (12:00 AM to 6:00 AM) drills were reviewed and indicated the following drills:</p> <p>2/27/13 at 5:30 AM, duration 1 minute and 20 seconds 3/1/13 at 5:00 AM, duration 2 minutes and 20 seconds 5/7/13 at 12:30 AM, duration 4 minutes and 22 seconds 5/28/13 at 4:00 AM, duration 2 minutes 7/23/13 at 2:00 AM, duration of 4 minutes and 28 seconds 12/24/13 at 4:00 AM, duration of 4 minutes and 13 seconds.</p> <p>On 2/25/14 at 12:00 PM during an interview, the Residential Coordinator (RC) was asked why there was a five month time gap between the 7/23/13 and 12/24/13 night time drills. The RC indicated the group home where Clients #1, #2, #3, #4, #5, #6, and #7 reside had a new House Manager (HM) at the end of 2013 which might account for a gap in overnight fire drills being</p>	W000440	W440The facility must hold evacuation drills at least quarterlyfor each shift of personnel. Emergency drills are conducted at least quarterly for eachshift of personnel and under varied conditions in order to ensure a safeenvironment for clients. The ResidentialManager received training regarding responsibility to ensure drill completionand monitoring on 1/30/14. (see attachment V) Residential staff received emergency drill trainingregarding the need for consistent running of drills on 1/23/14. (see attachment W) To ensure systemic compliance across the agency, allResidential Managers received training on 1/23/14. (see attachment X) To ensure ongoing compliance with drill completion, drillswill be monitored monthly by the Residential Managers and Coordinator. Drill completion and trends will be reportedmonthly to Director. Manager, Coordinator and Director Responsible.	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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
	completed. 9-3-7(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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			
W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control measures were implemented for 1 of 1 observed g-tube (gastronomy tube) feeding for a client requiring a g-tube feeding (#3).</p> <p>Findings include:</p> <p>On 2/24/14 between 4:35 PM and 6:15 PM and on 2/25/14 between 6:15 AM and 9:24 AM, group home observations were conducted. At 8:11 AM, DSP (Direct Support Professional) #1 assisted Client #3 with a g-tube (gastronomy tube) feeding. DSP #1 assisted Client #3 with alcohol gel to disinfect his hands and then, DSP #1 used alcohol gel to disinfect her hands. DSP #1 checked the g-tube for residue in Client #3's stomach prior to assisting Client #3 with the g-tube feeding. DSP #1 put clean gloves on her hands and began to assist Client #3 with the g-tube feeding. During the g-tube feeding, Client #3 began to cough. DSP #1 picked up the trash receptacle with her gloved hands, set it on her lap as she was seated in front of Client #3, and held the receptacle beneath the g-tube. The trash can had residue on the exterior surface. After Client #3 stopped coughing, DSP #1 set the trash receptacle down on the floor and continued to assist Client #3 with his g-tube feeding. DSP #1 did not change her gloves and proceeded to hold Client #3's g-tube and the syringe during the feeding.</p> <p>During an interview at 8:27 AM, DSP #1 stated "sometimes when he [Client #3] coughs, jevity</p>	W000454	W454The facility must provide a sanitary environment to avoidsources and transmission of infection. The facility will ensure that proper procedures are followedto ensure infection control for G-tube feedings. Direct Support Professionals received training on properinfection control for G-tube feedings. Direct Support Professionals received training on properinfection control for G-tube feeding on 3/26/14. (see attachment U) To ensure ongoing compliance with plan implementation, ShiftManagers will monitor each shift, Residential Managers will monitor daily, Nurseweekly and Coordinator will monitor quarterly.	04/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK 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>(g-tube liquid nutrition) comes out of the tube but we can't close the tube because it can give him a stomach ache so we grab the trash can to catch it."</p> <p>On 2/26/14 at 11:57 AM, the facility policy on "Communicable Disease Control Policy and Exposure Control Plan" dated 1/2013 was reviewed. The policy indicated "Universal precautions shall be observed to prevent contact with blood and other potentially infectious material." The policy indicated "gloves used for human contact shall be removed turning inside out and discarded after contact with each person, fluid, item or surface."</p> <p>On 2/27/14 at 12:45 PM during an interview, the facility Nurse indicated the proper infection control method after touching a trash receptacle during a g-tube feeding would have been to change gloves before touching Client #3's g-tube. The Nurse indicated all staff are trained in the use of Universal precautions.</p> <p>9-3-7(a)</p>			
--	--	--	--	--