

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G612	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2014
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 2/27, 3/3, 3/4, and 3/5/2014.</p> <p>Provider Number: 15G612 Facility Number: 001163 AIM Number: 100388230</p> <p>Surveyor: Susan Eakright, QIDP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/12/14 by Ruth Shackelford, QIDP.</p>	W000000		
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. Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility neglected to implement their policy and procedure for abuse, neglect, and/or mistreatment during medication administration and to supervise client #3 based on his identified behaviors.</p> <p>Findings include:</p>	W000149	<p>RM retrained staff on Abuse and Neglect policy at a house meeting on 03/18/14, specifically about reporting, neglect, and inadequate medical support. Staff were retrained on client #3 risk plan for PICA. Nurse retrained staff over the medication policy, specifically about not leaving meds unattended during house meeting on 03/18/2014. To ensure this</p>	03/21/2014

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

TITLE

(X6) DATE

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

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	<p>On 2/27/14 at 3:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations were reviewed from 7/2013 through 2/27/14 and indicated the following:</p> <p>-A 9/28/13 BDDS report for a medication error on 9/27/13 at 8:00pm, indicated client #3 from side A of the group home "sat at the ladies table (on side B) and ate [client #7's] snack which had [client #7's] evening meds (medications) in it that staff had sat (sic) down on the table when going to help" client #7 who had fallen down in the living room. The BDDS report did not indicate which of client #7's medications staff placed into her snack.</p> <p>-An undated investigation indicated GHS (Group Home Staff) #7 "stated that she prepared the medications in a bowl of ice cream and sat (sic) them at the table. [GHS #7] stepped away from the table to get [client #7] who had walked away. While [GHS #7's] back was turned [client #3] ate the ice cream with the medications: Melatonin 3mg (milligrams) (for anti anxiety medication), Atenolol .25mg (for hypertension), and Divalproex Sprinkles 125mg 6 (six) capsules (for seizures)."</p>		<p>deficiency does not occur again, the Residential Manager or shift manager will observe med passes until staff demonstrate competency. Once competency has been established, the Residential Manager will resume their normal observation schedule. (attachment 1, 2)</p>	

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	<p>On 3/4/14 at 10:00am, and on 3/4/14 at 2:30pm, client #3's record was reviewed. Client #3's 12/23/13 "Physician's Orders" and record did not include the use of Melatonin 3mg (milligrams) for anti anxiety medication, Atenolol .25mg for hypertension and Divalproex Sprinkles 125mg 6 (six) capsules for seizures. Client #3's 10/24/13 ISP (Individual Support Plan) and 10/24/13 SMP (Self Management Plan) both identified targeted behaviors of PICA (eating inedible items), eating other people's items, and indicated client #3 was to be supervised within the line of sight by the facility staff. Client #3's 10/2013 SMP indicated "I occasionally will pick up small items and put them in my mouth. I will also try to drink from other peoples' cups. I appear to enjoy taking the cup because when I am offered my own drink I often will not drink it."</p> <p>On 3/5/14 at 10am, a record review was completed of the facility's 1/2013 "Incident/Abuse/Neglect Policy" and procedures. The policy and procedure indicated the facility prohibited abuse, neglect, exploitation, and mistreatment. The policy and procedure indicated "...1.16 Medication Errors...a.)Wrong medication. b.) Wrong dose...2.4 Neglect: Incidents involving persons</p>						

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	<p>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>On 3/5/14 at 10am, a record review was completed of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 3/5/14 at 9:56am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the CSC (Community Services Coordinator) was conducted. The QIDP indicated the facility staff neglected to implement client #3's SMP. The QIDP indicated client #3 had the identified behavior of PICA and taking other clients' items to place in his mouth. The QIDP and the CSC both indicated the definition of neglect was the failure to provide appropriate care and/or supervision. The QIDP indicated client #3 did not possess safety skills to recognize that he should not have consumed client #7's ice</p>			

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W000218	<p>cream with medications. Both the QIDP and the CSC indicated the facility staff neglected to supervise client #3 when the incident occurred.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview, for 1 of 4 sample clients (client #1), the facility failed to assess client #1's functional ability related to his blindness and client #1's wheel chair use.</p> <p>Findings include:</p> <p>On 2/27/14 from 4:35pm until 6:10pm and on 3/4/14 from 5:00am until 8:30am, client #1 was non verbal and was visually impaired. During both observation periods, client #1 sat in a wheel chair with no leg rests, the wheel chair back sagged in the middle, and the seat of the wheel chair sagged with limited support for client #1's weight. During both observation periods, client #1 lay on a mat on the living room floor and crawled to different areas of the mat. During both observation periods, facility staff assisted client #1 to transfer from/to his wheel chair to the floor,</p>	W000218	<p>On 3/11/14 client #1 had an OT/PT evaluation completed at which time it was recommended for client #1 to use a wheelchair. Client #1 received a wheelchair evaluation and is currently being fitted for a new wheelchair. The RM and QDP were retrained on 3/21/14 to ensure staff are following an individual's schedule of use and to ensure all adaptive equipment is in good working order during observations. (attachment 3) On 3/18/14 DSPs were trained on how to run an OT/PT appointment, including sharing concerns and current adaptive equipment used. Additionally, the RM retrained DSPs on client #1's ISP. Training included using consistent interventions when working with client #1, including proper use of the wheelchair, transfers, activity choices, and food placement/identification. (attachment 4,5) Furthermore, the agency has requested a blind assessment from the League of the Blind and Visually Impaired</p>	03/21/2014

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	<p>from/to a regular chair, and from/to a mat which lay on the living room floor. During both observation periods, client #1 held out his hands each time staff verbally expressed a request for client #1 to complete.</p> <p>On 2/27/14 at 5:00pm, GHS (Group Home Staff) #2 and GHS #3 both indicated client #1 was blind and client #1's wheel chair did not fit him.</p> <p>On 3/4/14 at at 6:05am, client #1 sat in his wheel chair and was pushed out into the living room by GHS #5. At 6:30am, client #1 was transferred by GHS #5 from client #1's wheel chair to a mat on the living room floor. GHS #5 assisted client #1 to stand up from his wheel chair under client #1's arms. GHS #5 positioned herself in front of client #1, pivoted, and lowered client #1 onto the mat on the living room floor. GHS #5 moved client #1's body from the edges of the mat, positioned client #1's pillows under his head, and covered client #1 with a blanket. At 6:30am, GHS #5 indicated client #1 was blind. GHS #5 indicated client #1 used a wheel chair without leg rests from home and the wheel chair did not fit client #1's body type.</p> <p>On 3/4/14 at 7:10am, GHS #1 assisted</p>		<p>Services. (attachment 6) To ensure this deficiency does not occur again, PT/OT evaluation/wheel chair assessment has been added to the New Admission Check List. RM and Nurse will monitor that this is completed upon admission. Coordinator will oversee that this is completed. QDP and Residential Manager will increase observations to once per week on each shift until staff demonstrate competency. Once competency has been established, the Residential Manager and QDP will resume their normal observation schedule. (attachment 7)</p>		

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	<p>client #1 to a sitting position on the floor mat and lifted client #1 from behind under client #1's arms to a standing position. GHS #1 pivoted with client #1 and then encouraged client #1 to sit down in the seat of client #1's wheel chair. GHS #1 indicated client #1's wheel chair seat and back sagged and left gaps not fitting to client #1's body type.</p> <p>During both observation periods on 2/27/14 and 3/4/14 the facility staff used different interventions each time such as:</p> <p>-For client #1 to complete a request: GHS (Group Home Staff) #1 staff held client #1's hand when speaking with client #1 while other staff would verbally express face to face without touching client #1.</p> <p>-For transfers: GHS #5 lifted client #1 while being face to face with client #1 to assist client #1 with a transfer while GHS #1 lifted client #1 from behind and positioned themselves under client #1's arms.</p> <p>-For dining: GHS #2, GHS #5, and GHS #1 custodially prepared client #1's food on his plate for supper and breakfast; staff custodially cut each item into bite size pieces, and client #1 was encouraged to use a fork/spoon to eat.</p> <p>-For offering a choice of activity: GHS</p>			

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	<p>#1 placed the items in front of client #1 to reach out and take the choice item, while GHS #5 would place one item in each of client #1's hands and encourage him to choose the item client #1 wanted.</p> <p>-No identification of the wheel chair, no dimensions of the edges of the mat on the floor, no identification of the food on client #1's plate, and no descriptions of each choice activity were described to client #1.</p> <p>A review of client #1's record was conducted on 3/4/14 at 10:20am and on 3/4/14 at 3:00pm. Client #1's 12/18/13 ISP (Individual Support Plan) indicated a goal/objective to verbally say juice/water and to hold a fork/spoon with physical assist. Client #1's 12/18/13 visual assessment indicated his ocular health was stable and client #1 was legally blind. Client #1's 12/23/13 "Physician's Order" indicated client #1's diagnosis included but was not limited to: Legally Blind. Client #1's 2013 risk assessment indicated client #1 was blind and at risk for falls. Review of the record did not indicate a sensorimotor assessment of client #1's functional blindness. Client #1's 12/18/13 ISP and record indicated the use of a wheel chair to use for "community outings, transfers, and while visiting with the ladies" on the other side of the group home. Client</p>						

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W000368	<p>#1's 12/11/13 Physical Therapy (PT) and 12/11/13 Occupational Therapy (OT) assessments did not include the use of a wheel chair and did not include recommendations to assist with transfers.</p> <p>On 3/5/14 at 9:56am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Community Services Coordinator (CSC) was conducted. When asked if client #1 was assessed to address his functional skills related to his blindness and the use of a wheel chair, the QIDP stated "No." The QIDP indicated client #1 had no functional skill assessment completed for client #1's wheel chair use or blindness.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, for 2 of 4 sampled clients (clients #3 and #4) and 1 additional client (client #7), the facility staff failed to administer medications without error and as prescribed by the clients' physician.</p> <p>Findings include:</p>	W000368	Nurse retrained staff on Medication Policy at house meeting on 03/18/2014. She focused her training on omission errors, meds left unattended, wrong medications, and meds. given untimely. To ensure this deficiency does not occur again, the Residential Manager, Nurse, or shift manager will	03/18/2014

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	<p>On 2/27/14 at 3:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations were reviewed from 7/2013 through 2/27/14 and indicated the following:</p> <p>-A 1/13/14 BDDS report for a medication error on 1/13/14 at 12:00pm, indicated client #4 was "to be given a medication at noon and the pill was still in the packet. Staff initialed that they gave it...The missed medication was Gabapentin (for seizures) 600mg (milligrams) pill."</p> <p>-A 9/28/13 BDDS report for a medication error on 9/27/13 at 8:00pm, indicated client #3 from side A of the group home "sat at the ladies table (on side B) and ate [client #7's] snack which had [client #7's] evening meds (medications) in it that staff had sat down on the table when going to help" client #7 who had fallen down in the living room. The BDDS report did not indicate which of client #7's medications staff placed into her snack.</p> <p>-An undated investigation indicated GHS (Group Home Staff) #7 "stated that she prepared the medications in a bowl of ice cream and sat them at the table.</p>		observe med passes until staff demonstrate competency. Once competency has been established, the Residential Manager and Nurse will resume their normal observation schedule.. (attachment 2)	

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	<p>[GHS #7] stepped away from the table to get [client #7] who had walked away. While [GHS #7's] back was turned [client #3] ate the ice cream with the medications: Melatonin 3mg (milligrams) (for anti anxiety medication), Atenolol .25mg (for hypertension), and Divalproex Sprinkles 125mg 6 (six) capsules (for seizures)."</p> <p>-An 8/28/13 BDDS report for a medication error on 8/28/13 at 9:00am, indicated client #3 was given "another client's medication Lisinopril 10mg (for high blood pressure)" medication.</p> <p>-An undated investigation indicated GHS #9 stated "that she had given the wrong medication to [client #3]. [GHS #9] told me that she had gotten medications ready to give to client(s) on the men's side when the staff on the ladies side called for [GHS #9]. [GHS #9] locked (the) closet went and helped on (the) ladies side. When [GHS #9] returned to medication closet she gave the medication she had ready to [client #3] and it was [client #2's] medication."</p> <p>-An 8/3/13 BDDS report for a medication error on 8/2/13 at 8:00am, indicated client #7 "is to be given her Folitab (a multi vitamin with iron for nutritional health) every other day as</p>			

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	<p>prescribed by her doctor, the medication had been given on the 1st (first day of the month) as indicated on the medication card and MAR (Medication Administration Record), [GHS #8] gave Folitab on 8/2/13 when it should not have been given. [Client #7] should have been given her Vit (Vitamin) C (a vitamin supplement) and it remains in the pill packet."</p> <p>On 3/4/14 at 10:00am, and on 3/4/14 at 2:30pm, client #3's record was reviewed. Client #3's 12/23/13 "Physician's Orders" and record did not include the use of Lisinopril 10mg for high blood pressure medication, Melatonin 3mg (milligrams) for anti anxiety medication, Atenolol .25mg for hypertension, and Divalproex Sprinkles 125mg 6 (six) capsules for seizures.</p> <p>On 3/4/14 at 11:00am, client #4's 12/23/13 "Physician's order" indicated "Gabapentin (for seizures) 600mg (milligrams) pill."</p> <p>On 3/5/14 at 9:45am, client #7's 12/2013 "Physician's order" indicated Folitab a multi vitamin with iron for nutritional health every other day.</p> <p>On 3/5/14 at 9:00am, a record review was completed of the 2/2013 facility's</p>			

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W000436	<p>policy and procedures which indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home.</p> <p>On 3/5/14 at 9:00am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>On 3/5/14 at 9:56am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated staff did not follow physician's orders and when staff did not follow client #3, #4, and #7's physician orders the result would be considered a medication error.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4) with adaptive equipment, the</p>	W000436	RM trained staff over the use of the Go Talk and client #4 goal for the Go Talk at the house meeting on 03/18/2014. To ensure this	03/18/2014			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>facility failed to encourage the use of client #4's augmented communication device to communicate and to have the device available.</p> <p>Findings include:</p> <p>On 2/27/14 from 4:35pm until 6:10pm and on 3/4/14 from 5:00am until 8:30am, client #4 was non verbal and did not use a communication book and/or an augmented communication device to communicate. During both observation periods staff communicated verbal requests with limited gestures to client #4 and client #4 was not prompted to communicate with the group home staff.</p> <p>On 3/4/14 at 11:00am, client #4's record was reviewed. Client #4's 8/9/13 ISP (Individual Support Plan) indicated a goal/objective to use his Go-Talk communication device to communicate his wants/needs to the facility staff. Client #4's ISP indicated he was non verbal and used his augmented Go Talk communication device to communicate. Client #4's 4/10/2010 Speech Therapy (ST) assessment included recommendations for client #4 to use an output (augmented) device and the facility staff "should add gestures to requests" when communicating with</p>		<p>deficiency does not occur again, the QDP, Residential Manager, or shift manager will increase to daily observations until staff demonstrate competency. Once competency has been established, the Residential Manager and QDP will resume their normal observation schedule. (attachment 8)</p>				

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	<p>client #4.</p> <p>On 3/5/14 at 9:56am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Community Services Coordinator (CSC) was conducted. The CSC and the QIDP indicated client #4 had a Go Talk augmented communication device he was to use when staff or people he wanted to communicate. The QIDP indicated client #4's communication goal was in place to teach client #4 to use the Go Talk augmented device and should have been implemented during formal and informal opportunities. The QIDP indicated she did not know the current location of client #4's communication device.</p> <p>9-3-7(a)</p>			
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