

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(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
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: January 17, 18, 19, 20, and 23, 2012.</p> <p>Provider Number: 15G557 Facility Number: 001071 AIM Number: 100245470</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed on 1/30/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563		
(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	
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview, and record review, the governing body failed to exercise operating direction over the facility to ensure facility staff followed the facility's medication destruction policy and procedure</p> <p>Findings include:</p> <p>On 1/18/12 at 7:20am, medication administration was completed for client #5 at the group home with DCS (Direct Care Staff) #2. At 7:20am, client #5 was observed with DCS #2 in the medication room. At 7:20am, client #5 stood next to the tiered shelves which had stored/held apple sauce, bananas, and bottles of juice. On top of the eye level apple sauce containers in an unlabeled and unidentified baggie was a bright pink colored crushed medication pill. At 7:35am, client #2 stood next to the tiered shelves which had stored/held apple sauce, bananas, and bottles of juice. On top of the apple sauce containers in an unlabeled and unidentified baggie was a bright pink colored crushed medication pill. At 7:45am, DCS #2 stated the crushed pink colored material inside the unlabeled baggie on the shelves inside the</p>	W0104	<p>By February 22, 2012 facility staff will be retrained on the agency's Medication Policy, section 27.4, Procedure for Destruction of Medication, and Medication Destruction Form. This training includes how to properly destroy/dispose of dropped/spat out/refused medications. (See attachments A-1)This training also includes how to properly label and store a medication that has been dropped/spat out/refused in the event the medication is a controlled substance. The Residential Manager, QDP and Residential Nurse will ensure this policy/procedure is being followed during their monthly observation or as deemed necessary to ensure this deficiency does not occur again. Residential Manager, QDP, and Residential Nurse Responsible</p>	02/22/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>medication room "looks like a Carbamazepine (controlled medication for seizures) for [client #3]." DCS #2 stated "I didn't see it (the medication inside the unlabeled baggie) until you pointed it out." DCS #2 indicated the discarded medication should have been placed inside a baggie labeled with the client's name, the name of the medication, and the date of the dose which was to be discarded. DCS #2 locked the discarded medication stored in the unlabeled baggie inside the medication box. At 7:45am, DCS #2 stated he looked for a reason for the medication and stated "I have no documentation for that medication." DCS #2 indicated he did not know who's medication was inside the unlabeled baggie and he did not know what medication it was.</p> <p>An interview was conducted on 1/19/12 at 9:45am, with the Agency Registered Nurse (RN), the Agency Site Director (ASD), and the QMRP (Qualified Mental Retardation Professional). The three administrative staff indicated the staff should follow Core A/Core B Medication Training for medication administration. The RN stated she had "not been contacted by the group home staff" that a medication needed to be discarded. The RN stated she was "unaware" that the facility staff were putting discarded</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(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>medications "into an unlabeled baggie." The RN stated "the medication destroyed that were controlled medications" were to be in a labeled baggie and secured with a "required" two locks for security. The RN stated the staff did not "follow the medication destruction policy."</p> <p>On 1/19/12 at 9:45am, a record review of the the agency's 11/2011 "Medication Policy" indicated controlled substances "must" be double locked at "all times...Medication Disposal In the event a medication is discontinued, the following procedure will be followed, place the medication in a secured area in the med closet to be given to the nurse or returned to the pharmacy...The nurse will be responsible for securing all topical and liquid medications at least quarterly...Medications not in the punch pack that has been refused, dropped, or spit out will be disposed of by two staff by flushing down the toilet or rinsed down the sink and properly documented on the Destruction of Medication record...."</p> <p>9-3-1(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(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			
W0137	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review, and interview, for 2 of 2 sample clients (clients #1 and #2) and 2 additional clients (clients #5 and #8) who wore prescription eye glasses, the facility failed to allow clients #1, #2, #5, and #8 unimpeded access to their personal property.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/17/12 from 3:45pm until 6:07pm and on 1/18/12 from 6:55am until 9am. During both of the observation periods clients #2, #5, and #8 were not taught or encouraged to use their prescription eye glasses and clients were observed to work puzzles, cook, look at newspapers, and complete medication administration. Client #1 wore her prescribed eye glasses. On 1/18/12 at 7:50am, client #8 came out of his bedroom with his coat on for workshop and client #8 was prompted by DCS (Direct Care Staff) #1 to come to the staff office for his prescribed eye glasses for work. At 7:50am, client #8 went into the staff office, DCS #1 went behind the</p>	W0137	<p>On 1/30/2012 facility staff were retrained that all consumers are to have access to their personal belongings. All eyewear has been returned to clients #1, #2, #5, and #8 nightstand or dresser drawer. (See attachment J)By 2/22/12 facility staff will be retrained on Rights of Person Served training and an excerpt from the Consumer Handbook, which discusses all consumers having the right to keep their own personal possessions, including their (adaptive equipment). (See attachment K - O)Additionally, facility staff are required to sign off on the Rights of Person Served training on an annual basis. To ensure this deficiency does not occur again, the Residential Manager, QDP and Service Coordinator will ensure facility staff are giving consumer's unimpeded access to their belongings during monthly observations. Residential Manager, QDP and Service Coordinator Responsible.</p>	02/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(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>desk, opened a drawer, removed client #8's eye glass case, removed client #8's eye glasses, and client #8 put his eye glasses on independently. At 7:50am, DCS #1 showed client #1, #2, #5, and #8's eye glass cases located inside the desk drawer of the staff office and stated "we keep (the clients' eye glasses) in here cause we don't want them (the eye glasses) broken and the clients will refuse to wear them." DCS #1 stated "this way we can teach them" to wear their eye glasses.</p> <p>On 1/19/12 at 9:45am, an interview was completed with QDP (Qualified Developmental Professional) was completed. At 9:45am, the QDP indicated clients #1, #2, #5, and #8 wore prescribed eye glasses and stated "the eye glasses should be stored inside each clients case and inside each clients top drawer" of the dresser in client #1, #2, #5, and #8's bedrooms. The QDP stated she was "not aware" staff had client #1, #2, #5, and #8's prescribed eye glasses inside the staff office. The QDP indicated client #1, #2, #5, and #8 did not have unimpeded access to their personal property.</p> <p>Client #1's record was reviewed on 1/18/12 at 9:30am. Client #1's 3/17/11 ISP (Individual Support Plan) indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>she wore prescribed eye glasses. Client #1's record did not indicate an identified need for secured personal items.</p> <p>Client #2's record was reviewed on 1/18/12 at 10:20am. Client #2's 7/20/11 ISP indicated she had prescribed eye glasses. Client #2's record did not indicate an identified need for secured personal items.</p> <p>Client #5's records were reviewed on 1/18/12 at 9:15am. Client #5's 3/23/11 ISP and record did not indicate an identified need for secured personal items.</p> <p>Client #8's records were reviewed on 1/18/12 at 9:15am. Client #5's 11/30/11 ISP and record did not indicate an identified need for secured personal items.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563		
(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	
W0249	<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, interview, and record review, for 3 of 4 sample clients (client #2, #3, and #4), the facility failed to implement objectives/goals when opportunities existed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 1/17/12 at 5:30pm, client #4's pureed diet was custodially prepared by facility staff #1 and #3. From 5:30pm until 5:45pm, facility staff #1, #3, #4, and #5 served clients #1, #2, #3, #5, #6, #7, and #8 chili, broccoli, crackers, milk, and water at the table. Client #4 took bites of food from his plate one bite after another and facility staff #1 and #3 redirected him in excess of three times to wait until everyone was served. At 5:40pm, facility staff #4 without talking to client #4 picked up client #4's plate and moved the plate across the room to the counter in the kitchen behind client #4. Client #4 began to scoop his pudding thick milk and water from their glasses and eating them one bite after another without redirection to 	W0249	By 2/22/12 facility staff will be retrained on the following areas: (See attachment P) Staff will be retrained on client #4's sign language goal, at which time he is supposed to sign the word 'Thank You' at various times throughout the day. Furthermore, staff will be retrained on client #4's goal to pause between bites. (See attachments Q,R) Staff will be retrained on client #2's communication goal, which prompts her to be more independent in making choices by using gestures, touching and pointing. Additionally, staff will be retrained on client #2's behavior plan, which states staff should use gestures and pointing during communicatin. Furthermore, staff need to ensure they make eye contact when communicating. (See attachments S - U) Lastly staff will be retrained on client #3's communication goal which includes the use of a communication/picture book. (See attachment V) On 1/30/2012 the QDP provided initial training on the above mentioned programming concerns. (See attachment J). To ensure this	02/22/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563		
(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>pause between bites. At 5:45pm, client #4 had his meal plate returned to him by facility staff #3 and he consumed his food one bite after another and was not prompted to pause between bites.</p> <p>Client #4's record was reviewed on 1/18/12 at 10am. Client #4's 9/17/11 ISP (Individual Support Plan) indicated a goal/objective to sign word thank you and to wait five (5) seconds between bites of food while eating.</p> <p>On 1/19/12 at 9:45am, an interview with the QDP (Qualified Developmental Professional) was completed. At 9:45am, the QDP indicated client #4 was at risk for choking and should have been prompted to wait five (5) seconds before consuming his next bite which would include thickened liquids. The QDP indicated facility staff did not implement his plan for dining correctly.</p> <p>2. On 1/18/12 at 7:40am, client #2 was in the dining room with client #4. Client #2 yelled "I'm goin' get you" and walked behind client #4's chair where he was seated and hit him in the back of the neck. At 7:40am, facility staff #4 redirected client #2 from the living room without gaining client #2's eye gaze and client #2 hit client #4 again in the left arm. Client #4 made a waving motion toward client</p>		<p>deficiency does not occur again, the Residential Manager and QDP will conduct monthly observations which will include oversight in these areas. Residential Manager and QDP Responsible.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(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. At 7:40am, facility staff #4 came into the dining room and client #2 went with her.</p> <p>On 1/19/12 at 9:45am, an interview was completed with QDP was completed. At 9:45am, the QDP indicated client #2 yells "I'm goin get you" to client #4, "it's like a brother/sister thing." The QDP indicated staff should have client #2's eye gaze when redirecting her and when communicating with client #2.</p> <p>Client #2's record was reviewed on 1/18/12 at 10:20am. Client #2's 7/20/11 ISP indicated a goal/objective for client #2 to make a choice of objects. Client #2's ISP indicated she had limited speech skills. Client #2's 11/28/11 Speech Evaluation indicated a recommendation "Add gestures (and) commands or requests made to [client #2]" to communicate.</p> <p>3. Observations were conducted at the group home on 1/17/12 from 3:45pm until 6:07pm and on 1/18/12 from 6:55am until 9am. During both of the observation periods client #2 and #3 were not taught or encouraged to use communication books, pictures, or gestures to communicate their wants and needs to the facility staff.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(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 1/19/12 at 9:45am, an interview was completed with QDP (Qualified Developmental Professional) was completed. At 9:45am, the QDP indicated client #3 was to have a communication book available and used in the group home for client #3 to communicate with the facility staff. At 9:45am, the QDP indicated client #2 was to have her communication book available with pictures to pick out her clothing as a goal for client #2.</p> <p>Client #2's record was reviewed on 1/18/12 at 10:20am. Client #2's 7/20/11 ISP (Individual Support Plan) indicated a goal/objective for client #2 to make a choice of objects. Client #2's ISP indicated she had limited speech skills. Client #2's 11/28/11 Speech Evaluation indicated a recommendation "Add gestures (and) commands or requests made to [client #2]" to communicate.</p> <p>Client #3's record was reviewed on 1/18/12 at 10:55am. Client #3's 4/20/11 ISP indicated goals/objectives to identify happy from pics (pictures) in communication book and to choose an activity. Client #3's 2/24/07 Speech Evaluation indicated a recommendation "to use go talk for speech." Client #3's 4/20/11 ISP indicated client #3 was non verbal.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(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			
W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview, and record review, the facility failed to implement a plan to prevent recurrent skin ulcers for 1 of 1 sample client (client #3) with recurrent skin ulcers.</p> <p>Findings include:</p> <p>On 1/18/12 at 7:15am, DCS (Direct Care Staff) #4 stated client #3 had a pressure ulcer on her buttock "that was healing" and a "healed" right ankle ulcer. At 7:15am, client #3 seated in her wheelchair at the dining room table eating breakfast.</p> <p>On 1/19/12 at 9:45am, client #3's Skin tracking sheets were reviewed and indicated the following:</p> <p>-On 1/19/12 at 8am, "Location of pressure area Bottom area" length 1.0 centimeters (cm) width 1.5 centimeters, color red, treatment cream applied.</p> <p>-On 1/17/12 at 8am, "Location of pressure area Bottom area," length 1.0 cm, width 1.5 cm, color "a little red," and cream applied.</p> <p>-On 1/16/12 at 8:15am, "Location of pressure area Buttocks," length 1.0 cm, width 1.5 cm, color red, treatment cream applied.</p>	W0331	<p>On 1/17/12 client #3 plan of care for skin ulcers was updated by the Residential Nurse. (See attachment W) During the time of the survey, new orders were received by the client #3's family physician at which time the Residential Nurse had updated the plan of care. The plan was in the group home and staff were made aware of the updates. On 1/30/12 the Residential Nurse met with facility staff regarding client #3's plan and tested facility staff on their knowledge of the plan of care. (See attachments X & Y). As client #3's plan of care changes, staff are kept abreast of the new plan of care and orders from the physician and wound care clinic. The Residential Nurse examines client #3's ulcers on a weekly basis and reviews the documentation staff document regarding the ulcers to ensure the plan is being followed. Residential Nurse Responsible</p>	02/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(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 1/19/12 at 9:45am, client #3's 12/9/11 "Skin Assessment Tool" indicated client #3's buttock pressure area began on 12/9/11, on client #3's "Gluteal Cleft (measured) 1" (one inch) x 2mm (by two millimeters) stage 3." The assessment defined "Stage 3 Reassure Area" as "Break in skin exposing subcutaneous tissue." Client #3's "Skin Assessment Tool" indicated on 1/17/12 client #3's "Gluteal Cleft stage 2." The assessment defined "Stage 2" Pressure area as "Break in skin such as blisters or abrasions." Client #3's "Skin Assessment Tool" indicated an additional area "Labia Tears."</p> <p>During an interview on 1/19/12 at 9:45am, the Agency Registered Nurse (RN) provided documents for review and indicated client #3 had plans to take proactive measures to prevent further skin breakdown and for client #3's skin integrity while client #3 was up in her wheelchair. The RN stated measures were documented for client #3 to have creams applied and additional padding to her wheelchair to prevent further skin breakdown. The RN stated client #3 had the open area caused by pressure in the past on her buttocks and staff reported client #3's stage 3 pressure area "during the second week of December" of 2011. The RN stated client #3 "was at risk for</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(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>open pressure areas forming" and continued to be "at risk for more" skin areas breaking down. The RN indicated client #3's wheel chair had be adjusted in 12/2011 and had been adjusted again since she developed an open pressure area.</p> <p>On 1/18/12 at 10:35am, client #3's 4/20/11 ISP (Individual Support Plan) was reviewed. Client #3's ISP included a 4/20/11 "Risk Assessment" and 4/20/11 "Pressure Sore Plan" which both indicated client #3 was at risk to develop further skin breakdown. Client #3's 12/14/11 "Nursing Quarterly" record indicated on 12/9/11 client #3 developed a stage 3 pressure area on her buttocks. No plan to address recurrent skin ulcers was available for review.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(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			
W0391	<p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications had a pharmacy label to include client name and directions for the medication for 2 doses of 19 medications administered (for client #5).</p> <p>Findings include:</p> <p>On 1/17/12 at 4:48pm, medication administration was completed for client #5 at the group home with DCS (Direct Care Staff) #3. At 4:48pm, client #5 was observed with DCS #3 in the medication room. At 4:48pm, DCS #3 selected client #5's "neomyc Polyn (eye drops)" from a bin of client #5's medications, and administered one drop into each of client #5's eyes. At 4:50pm, client #5's 1/2012 MAR (Medication Administration Record) was reviewed and indicated "Neomyc Polyn (eye drops) 1 drop each eye twice daily" for dry eyes/allergies. At 4:50pm, DCS #3 indicated client #5's eye drops did not have a label on the bottle of eye medication to identify that the eye medication belonged to client #5. DCS #3 indicated client #5's pharmacy bottle which stored client #5's medicated eye drops had client #5's name on the storage</p>	W0391	<p>On 1/19/2012 client #5's neomyc Polyn eye drop bottle was relabeled by People's Pharmacy to include the consumer's name and RX numbers on the bottle. Furthermore, on 1/19/2012 the Residential Nurse notified People's Pharmacy about modifying labeling for all consumer medications where labeling identification would be seperate from the dispensing medication. (See attachment Z)All future medications will be monitored by the Residential Manager and Residential Nurse to ensure proper labeling. Residential Nurse and Residential Manager Responsible.</p>	02/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>bottle.</p> <p>On 1/18/12 at 7:20am, medication administration was completed for client #5 at the group home with DCS #2. At 7:20am, client #5 was observed with DCS #2 in the medication room. At 7:20am, DCS #2 selected client #5's "neomyc Polyn (eye drops)" from a bin of client #5's medications, and administered one drop into each of client #5's eyes. At 7:20am, client #5's 1/2012 MAR (Medication Administration Record) was reviewed and indicated "Neomyc Polyn (eye drops) 1 drop each eye twice daily" for dry eyes/allergies. At 7:28am, DCS #2 indicated client #5's eye drops did not have a label on the bottle of eye medication to identify that the eye medication belonged to client #5. DCS #2 indicated client #5's pharmacy bottle which stored client #5's medicated eye drops had client #5's name on the storage bottle.</p> <p>An interview was conducted on 1/19/12 at 9:45am, with the Agency Registered Nurse (RN), the Agency Site Director (ASD), and the QMRP (Qualified Mental Retardation Professional). The RN indicated client #5's medication bottle was not labeled and should have been. The RN stated it should have had the client #5's name on it.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------------	--	---------------------	--	----------------------------

	9-3-6(a)			
--	----------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

W0436	<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 observation, record review, and interview, for 2 of 2 sample clients (clients #1 and #2) and 2 additional clients (clients #5 and #8) who wore prescription eye glasses, the facility failed to teach and encourage the use of client #1, #2, #5, and #8 prescribed eye glasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/17/12 from 3:45pm until 6:07pm and on 1/18/12 from 6:55am until 9am. During both of the observation periods clients #2, #5, and #8 were not taught or encouraged to use their prescription eye glasses and clients were observed to work puzzles, cook, look at newspapers, and complete medication administration. Client #1 wore her prescribed eye glasses. On 1/18/12 at 7:50am, client #8 came out of his bedroom with his coat on for workshop and client #8 was prompted by DCS (Direct Care Staff) #1 to come to the staff office for his prescribed eye glasses for work. At 7:50am, client #8 went into the</p>	W0436	<p>By 2/22/12 facility staff will be retrained to ensure they teach and encourage the consumers who have prescriptions for eyeglasses, but refuse to wear them, to wear their eyeglasses during various training opportunities throughout the day. (See attachment aa) Facility staff will also be retrained on client #1, 2, 5, and 8's new goals/tracking sheets regarding their eyewear. Client #1 independently wears her prescribed glasses without issue. The QDP put a tracking sheet in place to ensure client #1 wears her prescribed eyewear. (See attachment bb) Client #2 now has a desensitizing chart for her eyewear that will have staff offering client #2 her glasses more frequently throughout the day. (See attachment cc) Client #5 now has a desensitizing chart for his sunglasses which explains he needs encouraged to wear his sunglasses while he is on an outing and/or outside. On 9/19/11 client #3's eye doctor stated client #5 does not need spectacles. (See attachments dd & ee) Client #8 independently wears his prescribed glasses without issue. The QDP put a</p>	02/22/2012
-------	--	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563		
(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 office, DCS #1 went behind the desk, opened a drawer, removed client #8's eye glass case, removed client #8's eye glasses, and client #8 put his eye glasses on independently. At 7:50am, DCS #1 showed client #1, #2, #5, and #8's eye glass cases located inside the desk drawer of the staff office and stated "we keep (the clients' eye glasses) in here cause we don't want them (the eye glasses) broken and the clients will refuse to wear them." DCS #1 stated "this way we can teach them" to wear their eye glasses.</p> <p>On 1/19/12 at 9:45am, an interview was completed with QDP (Qualified Developmental Professional) was completed. At 9:45am, the QDP indicated clients #1, #2, #5, and #8 wore prescribed eye glasses and stated "the eye glasses should be stored inside each clients case and inside each clients top drawer" of the dresser in client #1, #2, #5, and #8's bedrooms. The QDP stated she was "not aware" staff had client #1, #2, #5, and #8's prescribed eye glasses inside the staff office. The QDP indicated client #1, #2, #5, and #8 did not have unimpeded access to their personal property.</p> <p>Client #1's record was reviewed on 1/18/12 at 9:30am. Client #1's 3/17/11</p>		tracking sheet in place to ensure client #8 wears his prescribed eyewear. (See attachment ff)During monthly observation and time in the group home, the QDP and Residential Manager will ensure each consumer is taught the importance of wearing their eyewear as prescribed and/or instructed by the Optometrist. Residential Manager and QDP Responsible.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(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>ISP (Individual Support Plan) indicated she wore prescribed eye glasses. Client #1's ISP did not indicate a program to use the prescribed eye glasses.</p> <p>Client #2's record was reviewed on 1/18/12 at 10:20am. Client #2's 7/20/11 ISP indicated she had prescribed eye glasses. Client #2's ISP did not indicate a program to use her prescribed eye glasses.</p> <p>Client #5's records were reviewed on 1/18/12 at 9:15am. Client #5's 3/23/11 ISP and the record did not indicate a program to use the eye glasses.</p> <p>Client #8's records were reviewed on 1/18/12 at 9:15am. Client #5's 11/30/11 ISP and the record did not indicate a program to use the eye glasses.</p> <p>9-3-7(a)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563			
(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			
W0447	<p>The facility must file a report and evaluation on each evacuation drill.</p> <p>Based on record review and interview for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the facility, the facility failed to have documented completed evaluations and complete corrective actions for problems during emergency drills.</p> <p>Findings include:</p> <p>Facility records were reviewed on 1/18/2012 at 12noon, of the facility evacuation drills and indicated thirty-five of thirty-five (35 of 35) emergency evacuation drills completed by the facility had no comments, problems, or corrective action documented. The review indicated clients #2, #3, #5, and #6 had refused to exit during emergency evacuation drills twelve of thirty-five times (12 of 35) during the past twelve months and no corrective action was documented. At 12:20pm, the QDP (Qualified Developmental Professional) indicated no corrective action was available for review for the twelve times clients #2, #3, #5, and #6 refused to participate in the emergency drills. The QDP indicated no comments, problems, or corrective action were available for review. The QDP indicated each of the twelve drills in</p>	W0447	<p>On 2/8/2012 the Residential Manager was trained on how to ensure drills are properly documented, including providing corrective action for problems during the drill, appropriate length of time for a drill to occur and the new goals for person served who have identified issues completing the drills. By 2/22/12 facility staff will be retrained on the following:*length of time it should take to complete a fire drill*a review of the different areas on the Fire/Tornado Drill form and that it must be completely filled out*counseling person served who need to improve their evacuation times*new goals in place to assist client #2, 3, 5, and 6 increase their participation in completing drills*example fire drill(See attachments gg - oo)To ensure this deficiency does not occur again, the Residential Manager will review the completed Fire/Drill forms on a monthly basis to ensure accuracy and retrain if needed. Furthermore, the Service Coordinator will review the fire drills on a quarterly basis to ensure accuracy.Residential Manager and Service Coordinator Responsible.</p>	02/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 617 LOON CT PLYMOUTH, IN 46563
--	--

(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>which clients #2, #3, #5, and #6 had refused to exit by check mark on each drill. The QDP stated "twenty-two of thirty-five" emergency drill completion times for each drill "ranged from four minutes to seven minutes" and no corrective actions nor comments were documented on each of the twenty-two emergency drill reports.</p> <p>An interview was completed on 1/19/2012 at 9:45am, with the QDP, and the Site Coordinator (SC). Both the QDP and the SC indicated no additional information was available for review. Both indicated clients #2, #3, #5, and #6 had refused to participate to exit during the drills on twelve occasions. Both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 were dependent on facility staff to exit during an emergency and would not exit independently. The SC stated "any drill over three (3) minutes needs corrective action."</p> <p>9-3-7(a)</p>			
--	---	--	--	--