

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2016
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 330 E COLUMBIA LOGANSFORT, IN 46947
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: 1/19, 1/20, 1/25, 1/26, 1/27, 1/28, and 1/29/16.</p> <p>Facility Number: 001063 Provider Number: 15G549 AIM Number: 100245450</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/4/16.</p>	W 0000		
W 0260 Bldg. 00	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility failed to annually revise client #3's ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 1/20/16 at 12:30pm. Client #3's 7/12/2014 ISP (Individual Support Plan)</p>	W 0260	<p>Client's ISP was updated on 1/5/2016 (attachment A) It will be updated as necessary and at least annually Staff were trained on 1/26/16 over updated ISP (attachment B) QDP was trained on program monitoring and changes needed (attachment C) RM, QDP, and Coordinator will monitor for updated paperwork in the home during monthly observations to ensure compliance (attachment D and E)</p>	02/15/2016

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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W 0331 Bldg. 00	<p>was the most recent ISP in the record.</p> <p>On 1/25/16 at 8:36am, the QIDP (Qualified Intellectual Disabilities Professional) provided client #3's 1/2016 ISP.</p> <p>On 1/29/16 at 3:15pm, an interview with the Community Services Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and the QIDP both indicated client #3's documented ISP in the record was not reviewed annually. The CSC indicated client #3's 7/12/14 ISP was updated after the Surveyor requested the information and no additional information was available for review.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (client #2), the facility's nursing services failed to develop protocols specific to client #2's diagnosis of Kidney disease and to manage his diet related to his Kidney disease.</p>	W 0331	<p>To ensure this deficiency does not occur again, the Coordinator will review this procedure and all observations with QDP on a monthly basis during Office meetings until consistent compliance with the procedure is established. Responsible parties: QDP, RM, and Coordinator</p> <p>Kidney and skin integrity plan was developed by the nurse (attachment F) All staff were trained over the new plan (attachment G) QDP updated the ISP and reviewed with staff on 1/26/15 (attachment B and H) Change in protocol for updated plans – all medically prescribed changes / new diagnoses</p>	02/15/2016

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	<p>Findings include:</p> <p>Client #2's record was reviewed on 1/20/16 at 9:25am. Client #2's 12/21/15 and 9/23/15 "Physician's Orders" indicated client #2's diagnosis included, but was not limited to: Kidney Disease. Client #2's 1/28/15 ISP (Individual Support Plan) and 1/28/15 Risk Plans did not indicate client #2 was at risk for Kidney failure due to his Kidney disease. Client #2's 12/2015, 9/29/2015, 6/29/2015, and 3/25/2015 "Nursing Quarterly" reports did not indicate client #2's risk for Kidney problems related to his Kidney disease. Client #2's 12/2015 Nursing monthly did not indicate he was at risk for Kidney problems related to his Kidney disease. Client #2's record indicated he was non verbal, was able to use basic sign language, and used gestures/pointing to communicate his wants/needs. Client #2's record did not indicate a risk plan for his Kidney disease available for review. No information was available for review to determine how and if client #2 was able to identify his discomfort related to his Kidney disease. No guidelines, documented staff monitoring, or protocols for client #2's Kidney disease were available for review.</p> <p>On 1/20/16 at 11:00am, an interview with the agency's Licensed Practical Nurse</p>		<p>(OT/PT/Physician/Nutritionist, etc.) will require IDT oversight to ensure updates occur and staff are trained as prescribed. Any new or updated change to an individual's plan requires additional staff oversight until staff can demonstrate competency with the plan. Additional staff oversight includes an observation by the Residential Manger, QDP, Nurse, or Coordinator. Any pattern or intensity of events noted requires the IDT to convene and determine if the plan is effective, if staff are following the plan, and/or environmental factors to consider. Nurse will ensure to document at least quarterly about each diagnosis and any issues. The Coordinator must review all IDT notes and investigations. All staff trained on new procedure (attachment I) To ensure this deficiency does not occur again, the Coordinator will review this procedure with nurse on a monthly basis during Office meetings until consistent compliance with the procedure is established. Responsible parties: Nurse, RM, QDP, Coordinator</p>				

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	<p>(LPN) was conducted. The LPN indicated client #2's record did not include a risk plan for his Kidney disease. The LPN indicated client #2 was at risk for kidney problems because of his diagnosis of Kidney Disease.</p> <p>On 1/25/16 at 8:37am, the LPN provided client #2's 1/20/16 "Risk Plan Compilation: Chronic Kidney Disease / Skin Integrity" risk plan which indicated the following.</p> <p>- "High Blood Pressure-Diabetes-Obstruction from Kidney Stones."</p> <p>- "Baseline information, Kidney disease gradual loss of kidney function."</p> <p>- "Interventions: Staff will encourage toileting and proper skin care due to wearing depends. Staff will check skin for edema (which is) swelling of legs and ankles. Staff will encourage nutritional needs. Staff will encourage 64 ozs (ounces) of water daily. Staff will take blood pressure at least monthly. Staff will watch for side effects from meds. (medications). Staff will have labs done in a timely manner and see that [client #2] has re-check (sic) appts. (appointments)...Staff will monitor skin and document issues. Staff will monitor for pain or discomfort. Staff will monitor for edema in legs and ankles...Staff will monitor Blood pressure at least monthly</p>			

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W 0436 Bldg. 00	<p>(sic) if top number is higher than 140 and bottom number is higher than 90 will take BP (Blood Pressure) daily...Any signs of redness, swelling on skin or legs document in care tracker and notify nurse...."</p> <p>On 1/29/16 at 3:15pm, an interview with the agency Community Supports Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC indicated client #2 had physician's documentation for a diagnosis of Chronic Kidney Disease. The CSC indicated the LPN developed client #2's risk plan guidelines/protocols after the Surveyor had requested to review client #2's documentation regarding his Chronic Kidney Disease. The CSC indicated client #2 did not have completed risk plan guidelines and protocols for his Chronic Kidney Disease before 1/20/16 available for review.</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</p>				

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	<p>team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #2) with adaptive equipment, the facility failed to have client #2's prescribed eye glasses and more than one (1) adaptive drinking glass available and encourage client #2 to wear his prescribed eye glasses when opportunities existed.</p> <p>Findings include:</p> <p>On 1/19/16 from 3:45pm until 6:20pm and on 1/20/16 from 6:35am until 8:40am, client #2 was observed at the group home. During both observation periods client #2 was observed at the group home, used one (1) two handled nose flow glass (a special designed glass with one side of the glass cut out and with a handle on each side of the glass to allow the client more independence with drinking fluids) during meal times, and did not wear his prescribed eye glasses. During both observation periods and during the meals the Group Home Staff provided other clients three glasses for their choice of fluids and offered client #2 one choice of fluid. During both observation periods chocolate milk, white milk, water, coffee, two kinds of juice, and tea were offered for choice of drinks. During the observation periods the</p>	W 0436	<p>QDP developed a goal for clients glasses (attachment J) Staff were trained on new goal (attachment K) Staff were also trained to ensure that client has more than on drink at mealtimes Client should use a flow cup and staff should encourage him to take small sips after every 2-3 bites (attachment K) RM, QDP, and Coordinator will monitor for competency through observations weekly to ensure staff are competent and following through (attachment D and L) Documentation of observations will be reviewed by management/Coordinator weekly. To ensure this deficiency does not occur again, the Coordinator will review this procedure with staff on a monthly basis during house meetings until consistent compliance with the procedure is established.</p> <p>Responsible parties: QDP, RM, Coordinator</p>	02/15/2016

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	<p>facility staff did not encourage client #2 to wear his prescribed eye glasses and provided client #2 with a single nosey flow glass with two handles. During both observation periods client #2 fed himself a meal, completed medication administration, colored on paper, watched television, and matched color markers to his picture. On 1/20/16 at 8:25am, GHS (Group Home Staff) #2 indicated client #2 had one nosey flow glass with two handles available for his use and was provided one choice of fluid during meal opportunities.</p> <p>Client #2's record was reviewed on 1/20/16 at 9:25am. Client #2's 1/28/15 ISP (Individual Support Plan) did not indicate a goal to wear his prescribed eye glasses and use a two handle nosey glass to drink. Client #2's ISP indicated a list of adaptive equipment which included prescribed eye glasses. Client #2's 5/26/15 visual examination indicated client #2 wore prescribed eye glasses to see. Client #2's 11/2/15 and 10/12/15 "Quarterly Nutritional Review" indicated client #2 used an adaptive "flow cup." Client #2's 12/21/15 "Physician's Order" indicated client #2 used an adaptive "flow cup."</p> <p>On 1/29/16 at 3:15pm. an interview with the agency Community Supports</p>			

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W 0449 Bldg. 00	<p>Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and the QIDP indicated client #2 should be encouraged to wear his prescribed eye glasses to see. The CSC indicated client #2 wore prescribed eye glasses. The CSC indicated client #2 should have had more than one (1) adaptive nose flow cup to drink from during meals to encourage client #2 to drink different kinds of his choice of fluids.</p> <p>9-3-7(a)</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) who lived in the group home, the facility failed to initiate corrective action to prevent further incidents of lengthy evacuation drill times on the day, evening, and night shifts for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>Findings include: On 1/20/16 at 7:55am, record reviews</p>	W 0449	Investigation was conducted to determine the reasons for lengthy drills and corrective methods have been developed to ensure prompt evacuation Future drill will be monitored weekly by RM and Coordinator to ensure timely drills Staff were trained on Drill procedure (attachment M) RM, QDP, and Coordinator will monitor staff compliance though weekly observations until consistent compliance with procedure is established. (attachment D) Documentation of observations will be reviewed by management/Coordinator weekly. To ensure this	02/15/2016

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	<p>were completed of the facility's evacuation drills for the period from 1/2015 through 1/20/16 which included the participation of clients #1, #2, #3, #4, #5, #6, #7, and #8. The drills did not indicate a reason for each lengthy duration of the drill and did not include corrective measures to ensure prompt evacuation. The drills indicated the following:</p> <p>For day shift: On 8/27/15 at 6:05am, duration 12 minutes.</p> <p>For night shift: On 1/5/16 at 3:00am duration 12 minutes 47 seconds; on 11/4/15 at 2:00am duration 7 minutes 39 seconds; on 9/9/15 at 1:00am duration 10 minutes 45 seconds; on 5/26/15 at 4:00am duration 8 minutes 37 seconds; on 5/4/15 at 1:00am duration 6 minutes 20 seconds; and on 3/5/15 at 5:00am duration 5 minutes 33 seconds.</p> <p>On 1/20/16 at 8:10am, an interview was conducted with the RM (Residential Manager). The RM indicated each drill with a lengthy time duration to complete the drill was not investigated and no corrective action was completed. The RM indicated no additional information was available for review.</p>		<p>deficiency does not occur again, the Coordinator will review this procedure with staff on a monthly basis during house meetings until consistent compliance with the procedure is established. Responsible Party: RM and Coordinator</p>	

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	<p>On 1/29/16 at 3:15pm, an interview with the RM, the CSC (Community Supports Coordinator), and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RM, CSC, and the QIDP indicated there were no further documented drills for review. The CSC stated the evacuation drills had lengthy evacuation times because the clients "were dependent on staff" to complete each drill. The CSC stated clients #1, #2, #3, #4, #5, #6, #7, and #8 "required" verbal prompts and directions to exit and clients #3 and #5 "required" staff assistance physically to exit. The CSC stated client #3 "required" a hooyer lift transfer into a wheelchair, and staff physical assistance to exit. The CSC stated "No, none of the drills" included documentation for the reasons why each drill was lengthy in duration and did not include corrective measures to ensure prompt evacuation for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>9-3-7(a)</p>			