

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MITCHEL ST ROCHESTER, IN 46975
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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: 2/9, 2/10, 2/11, 2/16, 2/17, 2/18, and 2/19/16.</p> <p>Provider Number: 15G698 Facility Number: 003238 AIM Number: 200371780</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/1/16.</p>	W 0000		
W 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 1 of 4 sampled clients (Client #1), the facility failed to protect client #1's privacy when dressing and/or bathing.</p> <p>Findings include:</p>	W 0130	Staff were trained on client protections on 2/29/16 Staff will redirect anyone that is not involved in the care of the client away from the area and will keep doors closed during personal care (attachment A) RM, QDP, and Coordinator will monitor staff compliance and competency	02/29/2016

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 0159	<p>During observations on 2/10/16 from 6:05am until 7:55am, client #1 was at the group home. At 6:05am, client #1 was assisted to shower with GHS (Group Home Staff) #1 in the ladies side bathroom and the door was open to the hallway. At 6:05am, client #1, nude and seated in a shower chair, was in full view of the hallway on the ladies side. At 6:05am, the connecting door opened into the living room, client #6 walked into the ladies side of the group home, and client #6 stood in the hallway watching GHS #1 drying client #1's nude body with a towel while client #1 was seated in a shower chair in the bathroom. GHS #1 did not close the bathroom door and did not redirect client #6 to ensure client #1's privacy.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the CSC (Community Services Coordinator) was conducted on 2/19/16 at 2:15pm. The QIDP and the CSC both indicated client #1 should be taught and provided personal privacy during bathing. The CSC indicated client #6 should have been redirected.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION</p>		through observations (attachment B) Responsible parties: RM, QDP, Coordinator				

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Bldg. 00	<p>PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) was available and monitored clients #1, #2, #3, and #4's active treatment programs from 7/2015 through 1/2016.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/10/16 at 11:00am. Client #1's 3/31/15 ISP (Individual Support Plan) data was reviewed, and programs monitored by a QIDP on 3/31/15, 4/15, 5/15, 6/15, 7/15, and 1/27/16. No QIDP reviews and/or reviews of client #1's programs were available for review for 8/15, 9/15, 10/15, 11/15, and 12/15.</p> <p>Client #2's record was reviewed on 2/11/16 at 9:10am. Client #2's 1/17/16 ISP (Individual Support Plan) data was reviewed and programs monitored by a QIDP on 6/15, 7/15, and 1/17/16. No QIDP reviews and/or reviews of client #2's programs were available for review for 8/15, 9/15, 10/15, 11/15, and 12/15.</p> <p>Client #3's record was reviewed on</p>	W 0159	<p>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 B) 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.</p> <p>Responsible parties: QDP, RM, and Coordinator</p>	02/29/2016			

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	<p>2/11/16 at 9:45am. Client #3's 1/7/16 ISP (Individual Support Plan) data was reviewed and programs monitored by a QIDP on 1/15, 2/15, 3/15, 4/15, 5/15, 6/15, 7/15, and 1/7/16. No QIDP reviews and/or reviews of client #3's programs were available for review for 8/15, 9/15, 10/15, 11/15, and 12/15.</p> <p>Client #4's record was reviewed on 2/10/16 at 10:00am. Client #4's 4/23/15 ISP (Individual Support Plan) data was reviewed and programs monitored by a QIDP on 4/23/15, 5/15, 6/15, 7/15, and 1/27/16. No QIDP reviews and/or reviews of client #4's programs were available for review for 8/15, 9/15, 10/15, 11/15, and 12/15.</p> <p>On 2/19/16 at 2:15pm, an interview with the Community Services Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and the QIDP both indicated clients #1, #2, #3, and #4's documented QIDP reviews from 7/2015 through 1/2016 were not completed and reviewed by a QIDP. The CSC indicated clients #1, #2, #3, and #4's data, program implementation, monitoring their goals/objectives, and to oversee the services was not completed by a QIDP. The CSC indicated the facility had an opening for a QIDP from 7/2015 until the</p>						

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W 0268 Bldg. 00	<p>fall and after the new QIDP was hired no QIDP reviews of clients #1, #2, #3, and #4's plans were completed until 1/2016. The CSC indicated no additional information was available for review.</p> <p>9-3-3(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview, and record review, for 1 of 4 sampled clients (client #1), the facility failed to ensure client #1's dignity in regard to the client's clothing.</p> <p>Findings include:</p> <p>Observations and interviews were conducted at the group home on 2/9/16 from 5:00pm until 7:55pm. Client #1 was observed at the group home. During the observation periods client #1's pants sagged to expose her buttocks three to four inches (3" to 4") when client #1 walked, sat down, stood up, and bent over. On 2/11/16 at 8:55am, the RM (Residential Manager) indicated client #1's body type did not fit her clothing and the RM stated "thus, [client #1's] buttocks was always" exposed.</p>	W 0268	<p>The IDT continues to explore different styles of clothing that will fit client #1 body type appropriately. Staff were retrained on 02/29/2016 to assist client #1 in pulling up or changing her pants when they begin to sag. (attachment G) No other clients have this same issue in the home With client #1 we have tried many different clothing options and are still exploring to find an option that works 100% of the time Her body type makes this difficult because we do not want to limit her independence but also want to protect her dignity RM, QDP, and Coordinator will monitor staff compliance and competency through observations (attachment B) Responsible parties: RM, QDP, Coordinator, and IDT</p>	03/18/2016

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W 0331 Bldg. 00	<p>Client #1's record was reviewed on 2/10/16 at 11:00am. Client #1's 3/2015 CFA (Comprehensive Functional Assessment) indicated client #1 needed staff assistance to dress.</p> <p>On 2/19/16 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the CSC (Community Services Coordinator) was conducted. The CSC and QIDP both indicated client #1 should have been taught and encouraged to wear clothing to cover her buttocks. The CSC indicated client #1's body type did not fit her clothing to cover her buttocks when client #1's pants sagged. The CSC indicated staff failed to ensure client #1's dignity when she was not prompted to wear pants that fit her body type.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 4 sampled clients (clients #1, #3, and #4), the facility's nursing services failed to develop protocols specific to client #1, #3, and #4's medical diagnoses.</p>	W 0331	ISP and risk plans were updated to include information about heart problems, her pacemaker, seizure disorder, constipation, tachycardia, and supraventricular tachycardia for client #1. Staff were trained on the updated information on 02/29/2016	02/29/2016

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	<p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/10/16 at 11:00am. Client #1's 12/23/15 "Physician's Order" indicated client #1's diagnoses included, but were not limited to: Myopathy (a Neuromuscular Disorder), Seizure Disorder, Constipation, Tachycardia (heart rate disorder) with a Pacemaker, and Supraventricular Tachycardia (a faster than normal heart rate beginning above the heart's two lower chambers). Client #1's 3/31/15 ISP (Individual Support Plan) and 3/2015 Risk Plans did not indicate client #1 was at risk for heart problems, did not indicate she had a pacemaker, Seizure Disorder, Constipation, Tachycardia, and Supraventricular Tachycardia. Client #1's 12/17/15, 9/29/15, 6/29/15, and 3/25/15 "Nursing Quarterly" reports did not indicate client #1's risk for medical problems related to her heart, did not indicate she had a pacemaker, Constipation, Tachycardia, and Supraventricular Tachycardia. Client #1's record indicated she had limited verbal skills. No information was available for review to determine how and if client #1 was able to identify her discomfort related to her medical conditions. No guidelines, documented staff monitoring, or protocols for client</p>		<p>(attachment D, E, and F) Nurse was trained on including this information on her quarterly reports. Information of pacemaker was included in her quarterly reports (attachment H) Client #3 risk plan for seizures has been updated to include where the VNS magnet is located. Staff were trained on the update on 02/29/2016. (attachment I and J) Client #4 risk plan and ISP has been updated to include seizures and constipation Staff were trained over new plans on 2/29/16. (attachment K, L, M, N and N-1) RM, QDP, and Coordinator will monitor staff compliance and competency through observations (attachment B) Responsible parties: RM, QDP, Coordinator</p>		

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	<p>#1's heart problems, pacemaker, Seizure Disorder, Constipation, Tachycardia, and Supraventricular Tachycardia were available for review.</p> <p>2. Client #3's record was reviewed on 2/11/16 at 9:45am. Client #3's 12/23/15 "Physician's Order" indicated client #3's diagnoses included, but were not limited to: Epilepsy and Seizure Disorder. Client #3's 1/7/16 and 8/13/15 ISP (Individual Support Plan) and 1/2016 Risk Plans indicated client #3 was at risk for seizures. Client #3's 8/13/15 Seizure plan indicated the use of a VNS (Vagus Nerve Stimulator to treat seizures) and did not include where the staff were to keep the VNS magnet for its use to interrupt client #3's seizures. Client #3's record indicated she was non verbal and did not show signs before she experienced seizures. No further information was available for review.</p> <p>3. Client #4's record was reviewed on 2/10/16 at 10:00am. Client #4's 12/23/15 "Physician's Order" indicated client #4's diagnoses included, but were not limited to: Seizure Disorder and Constipation. Client #4's 4/23/15 ISP (Individual Support Plan) and 4/2015 Risk Plans did not indicate client #4 was at risk for seizures and constipation. Client #4's 12/17/15, 9/28/15, 6/29/15, and 3/25/15</p>			

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	<p>"Nursing Quarterly" reports did not indicate client #4's risk for medical problems related to her constipation and seizures. Client #4's record indicated she had limited verbal skills. No information was available for review to determine how and if client #4 was able to identify her discomfort related to her medical conditions. No guidelines, documented staff monitoring, or protocols for client #4's Seizure Disorder and Constipation were available for review.</p> <p>On 2/19/16 at 2:15pm, an interview with the CSC (Community Services Coordinator) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC indicated clients #1, #3, and #4's plans did not include specific risk protocols developed by the nursing services until 2/11/16 after the surveyor had requested risk plans for client #1's heart problems, pacemaker, Seizure Disorder, Constipation, Tachycardia, and Supraventricular Tachycardia, client #3's VNS seizure magnet storage, and client #4's Seizure Disorder and Constipation. The CSC indicated clients #1, #3, and #4 had physician's documentation for each of their medical diagnoses. The CSC indicated clients #1, #3, and #4 did not have completed risk plan guidelines and protocols for their chronic medical</p>						

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W 0382 Bldg. 00	<p>problems before 1/20/16 available for review.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8), the facility failed to keep medications locked when not being administered for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>Findings include:</p> <p>Observations and interviews were conducted at the group home on 2/9/16 from 5:00pm until 7:55pm. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. During the observation period clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to walk and access both sides of the group home. During the observation period the medication cabinet was left unlocked and unsecured inside the unlocked linen closet at the group home. On 2/10/16 from 6:05am until 7:55am, the ladies side medication cabinet was left unlocked however it was behind a locked linen</p>	W 0382	The ladies medication cabinet lock broke the evening of 02/09/2016 The RM placed a maintenance request that morning when it was discovered The locking mechanism was fixed on 02/11/16 (attachment O) Staff were trained on 02/29/16 to lock the closet if the cabinet lock breaks in the future until the lock can be repaired The nurse reviewed the Core Lesson 3 from Med Core A/B with staff on 02/29/2016 (attachment N and N-2)	02/29/2016

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	<p>closet door. On 2/10/16 at 7:30am, GHS (Group Home Staff) #8 indicated the ladies side medication cabinet door was broken and could not be locked/secured. GHS #8 indicated the linen closet was locked to keep the medications on the ladies side secured until the medication cabinet door was repaired.</p> <p>On 2/19/16 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the CSC (Community Services Coordinator) was conducted. The CSC and QIDP indicated medications should be kept secured when not administered. The CSC indicated the facility followed Core A/Core B Living in the Community for medication administration and medication security. The CSC indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to unsecured medications inside the medication cabinet on the ladies side.</p> <p>On 2/19/16 at 2:15pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured when not administered.</p> <p>9-3-6(a)</p>						

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W 0383 Bldg. 00	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cart keys for 4 of 4 sampled clients (#1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>Observations and interviews were conducted at the group home on 2/9/16 from 5:00pm until 7:55pm. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. During the observation period clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to walk and access both sides of the group home. During the observation period the medication keys for the medication cabinet on the men's side of the group home were left unsecured on top of the locked medication cabinet. On 2/10/16 from 6:05am until 7:55am, the men's side medication cabinet keys were kept secured by GHS (Group Home Staff) #9. On 2/10/16 at 7:30am, GHS (Group Home Staff) #8 indicated the men's side medication cabinet keys should have been kept secured by the facility staff.</p>	W 0383	<p>Staff were trained by the nurse on 02/29/2016 over Med Core A/B Core lesson 3 Staff were reminded that medication cabinet keys should remain on staff's person at all times (attachment N and N-2) Staff will be monitored for compliance and competency by RM, QDP, and Nurse through observations (attachment B) Responsible parties: RM, QDP, Coordinator, and Nurse</p>	02/29/2016

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W 0436 Bldg. 00	<p>On 2/19/16 at 2:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the CSC (Community Services Coordinator) was conducted. The CSC and QIDP indicated medication cabinet keys for the men's side of the group home should be kept secured by the facility staff. The CSC indicated the facility followed Core A/Core B Living in the Community for medication administration and medication key security. The CSC indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the unsecured medication cabinet keys on the men's side of the group home.</p> <p>On 2/19/16 at 2:15pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medication cabinet keys should be kept secure.</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,</p>			
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MITCHEL ST ROCHESTER, IN 46975
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	<p>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 4 sampled clients (clients #1 and #3), the facility failed to teach and encourage client #1 to wear her prescribed eye glasses and failed to ensure client #3's VNS (Vagus Nerve Stimulation a magnet used to treat seizures) magnet for seizure control was available for use.</p> <p>Findings include:</p> <p>1. On 2/9/16 from 5:00pm until 7:55pm, client #1 was observed at the group home and did not wear her prescribed eye glasses. During the observation period client #1 watched television, looked at a book and magazine, and chose activity items from a closet of supplies which included coloring on paper, writing on paper, and cutting paper.</p> <p>On 2/10/16 from 6:05am until 7:55am, client #1 was observed at the group home and did not wear her prescribed eye glasses. During the observation period client #1 walked throughout the group home, dressed, ate breakfast, completed medication administration, colored on paper, and looked at a book. At 7:55am, the surveyor asked client #1 if she wore</p>	W 0436	<p>QDP developed a goal for client #1 for her eyeglasses and added the information to the ISP. Staff were trained over the new goal on 02/29/2016 Staff are to encourage client #1 to wear her glasses when she begins getting ready for the day If she refuses staff are to let her know the benefits of wearing glasses If she refuses again, she is to be offered her glasses at the next training opportunity This can be when she is working on puzzles, cooking, looking at magazines, medication passes, watching TV, etc Staff should offer her glasses several times a day (attachment P, Q, and R) QDP added information to Client #3's ISP and risk plan indicating where the VNS magnet is located Staff were trained over the location on 02/29/2016 (attachment J) RM, Nurse, QDP will monitor staff compliance and competency during observations (attachment B) Responsible Parties: Nurse, QDP, Coordinator and RM</p>	02/29/2016

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	<p>prescribed eye glasses and client #1 indicated yes.</p> <p>On 2/10/16 from 9:40am until 12:05pm, client #1 was observed at the group home. From 9:40am until 11:00am, client #1 did not wear her prescribed eye glasses. During the observation period client #1 assembled Valentine Cards, looked at a computer screen, and looked at books. At 11:00am, GHS (Group Home Staff) #10 walked to the six foot shelf in the living room on top of the television stand and retrieved a pair of prescription eye glasses, returned to client #1, and prompted client #1 to wear her eye glasses. At 11:00am, GHS #10 indicated client #1 wore prescribed eye glasses and the glasses were kept on top of the television.</p> <p>Client #1's record was reviewed on 2/10/16 at 11:00am. Client #1's 3/31/15 ISP (Individual Support Plan) did not indicate a goal to wear her prescribed eye glasses. Client #1's 12/18/13 Vision assessment indicated client #1 wore prescribed eye glasses to see.</p> <p>On 2/19/16 at 2:15pm, the CSC (Community Services Coordinator) indicated client #1 wore prescribed eye glasses to see and should have been taught and encouraged to wear her</p>			

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	<p>prescribed eye glasses.</p> <p>2. On 2/9/16 from 5:00pm until 7:55pm, and on 2/10/16 from 6:05am until 7:55am, client #3 was observed seated in a wheelchair, was non verbal, and did not have a VNS magnet for seizures accessible to her.</p> <p>On 2/10/16 at 9:40am, client #3 sat in a wheelchair and had a VNS magnet attached to her wheelchair arm. At 9:40am, GHS #9 and GHS #10 both indicated client #3's seizure magnet was located after the surveyor inquired regarding the VNS magnet after morning medication administration. GHS #9 indicated client #3's seizure magnet had been misplaced into a box for client #1's new heart monitor inside the medication room.</p> <p>Client #3's record was reviewed on 2/11/16 at 9:45am. Client #3's 1/7/16 ISP indicated she used a Vagus Nerve Stimulation (VNS), a magnet for seizures and staff "should know (the location of) where magnet" was stored/kept. Client #3's 8/3/15 Neurology visit indicated client #3 used a VNS for seizure control. Client #3's diagnoses included, but were not limited to Epilepsy and Seizure Disorder. Client #3's 12/23/15 Physician's Order indicated the use of a</p>			

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W 0454 Bldg. 00	<p>VNS for seizures.</p> <p>On 2/19/16 at 2:15pm, an interview was conducted with the CSC. The CSC indicated client #3 used a VNS seizure magnet and staff should have kept the magnet near client #3 to interrupt her seizures. The CSC stated staff should have known the location of client #3's VNS "at all times."</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #2) who had medications administered, the facility failed to follow Universal Precautions for client #2's dropped medication tablets.</p> <p>Findings include:</p> <p>On 2/10/16 at 6:37am, GHS (Group Home Staff) #9 asked client #2 to come to the medication closet. GHS #9 did not wipe and/or disinfect the top of the medication cabinet. GHS #9 provided hand over hand assistance to client #2 to pop out client #2's Levothyroxine 75mg</p>			W 0454	<p>The nurse trained staff over infection control and universal precautions on 02/29/2016 (attachment N and N-3) RM, QDP, and Coordinator will monitor staff compliance and competency through observations (attachment B)</p> <p>Responsible parties: Nurse, QDP, RM, Coordinator</p>		02/29/2016

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	<p>(milligrams) for the thyroid. The pill missed the medication cup, then landed on the unclean medication cabinet top. GHS #9 picked up the dropped Levothyroxine medication tablet, placed it into client #2's medication cup with his other medications, and prompted client #2 to take the medications. At 6:37am, client #2 consumed the medications and left the medication closet.</p> <p>On 2/19/16 at 2:15pm, an interview and record review with the CSC (Community Services Coordinator) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted. The CSC and QIDP both indicated facility staff should have followed Core A/Core B medication training manual, dated 2004, for Universal Precautions. On 2/19/16 at 2:15pm, the Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions should be used in maintaining the cleanliness of the medication area...To begin, clean the surface thoroughly with soap and water...." The CSC indicated client #2's pill should have been discarded and a clean tablet dispensed. The CSC indicated the medication cart top should have had a barrier between the top of the medication cart and the medications dispensed. The CSC indicated staff could have wiped the area to clean before</p>			

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W 0475 Bldg. 00	<p>administering medications.</p> <p>9-3-7(a)</p> <p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils.</p> <p>Based on observation and interview, for 1 of 4 sampled clients (client #2) and 3 additional clients (clients #5, #6, and #8), the facility failed to have serving dishes, napkins, and a full set of standard utensils available for use during dining opportunities.</p> <p>Findings include:</p> <p>On 2/9/16 from 5:00pm until 7:55pm and on 2/10/16 from 6:05am until 7:55am, clients #2, #5, #6, and #8 were observed on the men's side of the group home. During both observation periods clients #2, #5, #6, and #8 were not provided a napkin, were provided a spoon to eat, and no fork and knife were offered by the facility staff during dining. During the observation period on 2/10/16 at 6:52am, GHS (Group Home Staff) #7 assembled clients #2, #5, #6, and #8's cereal, scrambled eggs, and cut up toast onto four separate plates on the counter. During the morning observation no serving dishes were used.</p>	W 0475	Staff were trained on 02/29/2016 over Facility Practices Utensils, adaptive equipment, family style, and condition of equipment was discussed (attachment S) RM, QDP, and Coordinator will monitor staff compliance and competency through observations (attachment B) Responsible parties: RM, QDP, and Coordinator	02/29/2016

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	<p>On 2/19/16 at 2:15pm, an interview with the CSC (Community Services Coordinator) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and QIDP indicated clients #2, #5, #6, and #8 should use serving dishes during family style dining, a full set of utensils, and napkins at the group home.</p> <p>9-3-8(a)</p>				