STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G294	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL SERVICES INC OF INDIANA	1763 HARTZLER WARSAW, IN 46580

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W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: 8/4, 8/5, 8/6, and 8/7/2015. Provider Number: 15G294 Facility Number: 000813 AIM Number: 100235010 These federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0268 Bldg. 00	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 and interview, for 1 of 4 sampled clients (client #2), the facility failed to encourage and teach client #2 personal privacy when opportunities existed. Findings include: On 8/4/15 from 1:50pm until 3:00pm, observation was conducted at the facility owned day services of client #2. From 1:50pm until 3:00pm, client #2 was observed to wear black slacks with an	W 0268	**W268** These policies and procedures must promote the growth, development and independence of the client. Cardinal Services' expectation is that each individual we serve be treated with dignity and respect. Direct Support staff working within the home as well as in Day Services received training on 8/20/15 that dignity and respect includes, but is not limited to, encouraging person served to wear clothing that fits	08/25/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	elastic waist band. At 1:50pm, client #2 sat in a chair upright, eating chocolate pudding from a container, and from the back of the chair two to three inches (2" to 3") of client #2's buttocks was observed to be exposed. At 2:50pm, client #2 was observed to walk around the classroom, bent over to pick items up from the floor, her pants fell down below her buttocks, and client #2's buttocks were observed to exposed. Client #2 was observed to pull her black pants up continuously while she walked around the classroom area. On 8/4/15 from 4:25pm until 5:55pm, client #2 was observed at the group home and wore black pants. At 4:25pm, client #2 arrived home on the facility's bus from day services. Client #2 began to walk down the four steps of the facility bus to exit the bus, and her pants began to fall downward exposing client #2's buttocks area. Client #2 grasped the waist band of her pants, pulled upwards on her pants, and continued to walk down the bus steps. As client #2 walked from the bus exit at the end of the driveway, up the driveway, through the garage, and into the group home, client #2's pants fell downward to expose her bare buttocks. At 4:40pm, client #2 was prompted by the RM (Residential Manager) to pull up her pants after the RM told client #2 she		their bodies appropriately and/or wear suspenders or a belt to aid in keeping their pants on their waist (See Attachment A). An informal goal was implemented in the residential setting as well as in the day service setting on 8/20/15 for client #2 to purchase clothing that fits her body appropriately as well as to work with staff daily prior to leaving the home to ensure she has pants on that fit her waist appropriately (See Attachments B, C). All Direct Support staff working with client #2 in her home as well as day services received training on 8/20/15 (See Attachments D). To ensure this deficiency does not occur again, the Residential Manager, QDP and Coordinator will monitor the implementation of dignity and respect through weekly, monthly, and quarterly observations. **Residential Manager, QDP, and Coordinator responsible.**	

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	had noticed client #2's pants falling down. From 4:40pm until 4:45pm, client #2 fixed a snack, carried the snack to the dining room table, sat down in a dining room chair, and exposed two to three inches (2"-3") of her buttocks when seated. From 4:45pm until 5:15pm, client #2 sat in her bedroom. From 5:15pm until 5:55pm, client #2 walked throughout the group home, wore the same black pants which fell down two additional times, and client #2's pants fell down when she was seated to expose client #2's buttocks. On 8/5/15 at 8:50am, an interview with the agency's LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #2's clothing should protect her personal privacy and client #2's buttocks area should not be visible to others. On 8/5/15 at 12:15pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the group home had female clients living there. The QIDP indicated client #2 should have been redirected during formal and informal opportunities to teach and encourage her personal privacy. The QIDP indicated client #2's clothing should protect privacy.			

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	9-3-5(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility's nursing services failed to develop a pain management plan/protocol to ensure the facility staff implemented physician's orders and administered client #4's pain medications to monitor and/or to manage her pain. Findings include: On 8/5/15 from 5:30am until 7:45am, client #4 was observed at the group home. From 5:30am until 5:50am, client #4 dressed herself for the day inside her bedroom. At 5:50am, client #4 walked with her legs straight and without bending her legs to the kitchen/dining room. At 5:50am, client #4 was non verbal and used sign language to communicate with GHS (Group Home Staff) #1 that she was in pain and wrinkled her face in a grimace and her eye brows were leveled. From 5:50am until 6:15am, client #4 used sign language five (5) additional times to communicate to GHS #1 that she was	W 0331	**W331** The facility must provide clients with nursing services in accordance with their needs. The Residential Nurses received training regarding the development of client specific care plans on 8/17/15 (see attachment E). A Pain Management Care Plan was implemented for Client #4 to reflect specific individualized guidelines for assessing and treating this individual on 8/20/15 (See Attachment F). Staff were trained on the plan on 8/20/15 (See Attachment G). All Direct Support Staff working in the home received training on Pain Management instructions on 8/20/15 (See Attachment H). All Adult Service staff within the Company will receive training on the Pain Management instruction by 9/6/15. All Direct Support staff working in the home received training on Information for Pain Tracking from the Med Manual on 8/20/15 (See Attachment I). All Adult Service staff within the Company will receive training on Pain Tracking from the Med Manual by 9/6/15. The Residential Nurse	08/25/2015

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	having pain in her hip and requested medication for the pain. Each time client #4 requested pain medication for her pain, GHS #1 stated to client #4 to "wait awhile. I know you're in pain." At 6:15am, GHS #1 indicated verbally she was going to pass the 6:00am medications for clients. Client #4 walked with a stiff gait into the medication room and GHS #1 verbally prompted client #4 to wait for client #4's medications. Client #4 left the medication room, and GHS #1 requested client #8 to come to the medication room. At 6:35am, GHS #1 requested client #4 to come into the medication room. Client #4 walked with a stiff gait into the room, used sign language to communicate she was in pain, and requested pain medication from GHS #1. At 6:35am, GHS #1 compared client #4's "Tramadol HCL 50mg (milligrams) (for pain), 1 tablet every 6 (six) hours as needed for pain scale of 5 or less and 2 tablets for scale of 6 or more on pain scale" medication label to client #4's 8/2015 MAR (Medication Administration Record). GHS #1 punched the tablet into a medication cup and client #4 took the medication. GHS #1 did not have client #4 rate her pain on a pain scale. At 6:35am, GHS #1 selected client #4's "Compound Pain Cream (mixed by the pharmacy specific for client #4's pain), apply 1-2 pumps to		verified orders on the MAR for client #4 were correct on 8/11/15 and found there to be only 1 order for client #4's Tramadol HCL 50mg (See Attachment J). The original order for the Tramadol and Compound Cream was written by the prescribing Physician on 4/16/15 (See Attachment K). The order for Tramadol was changed by the prescribing Physician on7/8/15 (See Attachment L). The current MARs reflect the new order (See Attachment J). To ensure this deficiency does not occur in the future, the Coordinator will monitor care plans for thoroughness in amendments through documentation review and internal audits. Spot checks will be completed by the Coordinator monthly and each time a new care plan is implemented it will be reviewed for thoroughness and accuracy. The Residential Nurse will ensure ongoing compliance through weekly, monthly and quarterly observations. **Support Services Coordinator and Residential Nurse responsible**.	

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	the area 3-4 times daily" on the medication label, placed two squirts onto her gloved hand, and applied the compound pain cream to client #4's left hip area. GHS #1 rubbed the cream in lightly into client #4's skin, and client #4 had facial grimaces and cried out indicating she was in pain. On 8/5/15 at 6:45am, GHS #1 indicated when she applied the cream to client #4's skin that client #4 was in pain. GHS #1 indicated she did not have client #4 rate her pain because client #4 was inconsistent when the staff used a pain scale. GHS #1 located a pain scale from 1 to 10. The pain scale had pictures of faces with one meaning no pain with a picture of a happy face and 10 being the greatest pain with a picture of a face crying. GHS #1 stated client #4 "used to use this" to indicate the type of pain she had and indicated the staff give her the medications when client #4 asked for medication. GHS #1 stated client #4 "was almost always in pain when she asked for medication." When asked why client #4 had to wait for pain medications from 5:30am until now, GHS #1 indicated she waited until she started medication pass to give client #4 pain medications. When asked when client #4 last received her pain medications, GHS #1 indicated it was 7:00pm on 8/4/15.			

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	When asked what staff used to determine the type and level of pain client #4 was experiencing and how much medication to administer to client #4, GHS #1 stated client #4 had "no current" pain management plan and stated "Staff just know." GHS #1 indicated client #4's 8/2015 MAR which indicated "Tramadol HCL 50mg, take 1 tablet in the morning and 1 tablet in the evening" had not started on 8/5/15 and the MAR had a written note "new order 7/17/15." On 8/5/15 at 6:45am, client #4's 8/2015 MAR indicated "Tramadol HCL 50mg (milligrams) (for pain), 1 tablet every 6 (six) hours as needed for pain scale of 5 or less and 2 tablets for scale of 6 or more on pain scale, Compound Pain Cream (mixed by the pharmacy specific for client #4's pain), apply 1-2 pumps to the area BID (twice daily), (and) Tramadol HCL 50mg, take 1 tablet by mouth every morning and 1 tablet in the evening (for pain) new order 7/17/15," and client #4's new Tramadol HCL 50mg MAR section was blank indicating the medication was not being administered. On 8/5/15 at 10:00am, client #4's record was reviewed. Client #4's 7/17/15 "Physician's Order" from the physician at the Pain Center indicated "Tramadol ER 100mg, every 12 hours routinely" for			

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	pain. Client #4's 4/23/15 "Physician's Order" from her attending physician indicated "Tramadol HCL 50mg, take 1 tablet by mouth every 6 to 8 hours as needed for pain PRN" and "Compound Pain Cream (mixed by the pharmacy specific for client #4's pain), apply 1-2 pumps to the area 3-4 times daily." No pain management plan/protocol was available for review. No nursing notes were available for review to ensure client #4's physician's orders were reconciled to ensure client #4's physician's orders matched client #4's current MAR for her medications to be administered. On 8/5/15 at 8:50am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #4 had physician's orders for as needed pain medications, routine pain medications, and client #4 should have received the pain medication any time she requested it. The LPN indicated the facility followed Core A/Core B Living in the Community policy and procedure for medication administration. The LPN indicated the labels should match for each medication, the physician's order, and the current MAR. The LPN indicated the staff should have used a facial pain scale for client #4 and indicated she was unsure if client #4 had a pain management plan/protocol.			

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	On 8/5/15 at 1:00pm, a record review of the facility's 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. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, for 1 of 23 medications administered at the group home (client #6), the facility failed to ensure client #6's medications were given without error. Findings include: On 8/5/15 at 7:28am, client #6 was asked by GHS (Group Home Staff) #1 to come into the medication room. At 7:28am, GHS #1 asked client #6 to blow her nose before medications were administered and client #6 blew her nose. At 7:28am, GHS #1 unlocked the medication cabinet, retrieved client #6's medication of "Saline	W 0369	**W369** The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Cardinal Services, Inc. has in effect procedures to assure safe and responsible administration of prescription and non-prescription medication as well as a tracking process to provide training and discipline for non-compliance. Direct Support staff #1 received training on medication administration procedures on 8/15/15 (See Attachment M). Staff #1 completed and passed a medication error competency test on 8/18/15 (See Attachment N).	08/25/2015

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	0.65%, use 3-4 sprays in each nostril then blow nose," and compared the label to client #6's 8/2015 MAR (Medication Administration Record)." At 7:28am, GHS #1 removed the lid from client #6's Saline 0.65% medicated spray, handed the medication to client #6, instructed client #6 to dispense the medication, and client #6 sprayed one spray into each nostril. GHS #1 stated "Can you do it again?" and client #6 applied a second spray into each nostril. GHS #1 recapped the medication and client #6 was not instructed to blow her nose. On 8/5/15 at 7:35am, client #6's 8/2015 MAR indicated "Saline 0.65%, use 3-4 sprays in each nostril then blow nose once daily." On 8/5/15 at 12noon, client #6's 4/28/15 Physician's Orders indicated "Saline 0.65%, use 3-4 sprays in each nostril then blow nose once daily." On 8/5/15 at 1:00pm, the facility's 3/2015 policy and procedures for "Medication Administration" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage...Check the medication listed on the medication		Staff #1 did not administered medications after the medication error until after she was observed by the Residential Nurse for competency on 8/19/15 (See Attachment O).All Direct Support staff working in the home received training on medication administration procedures on 8/20/15 (See Attachment P). All Direct Support staff working in the home received training concerning Pain Management, which includes guidelines to assess pain severity and procedures to monitor the effectiveness of that pain medication once given on 8/20/15 (See Attachment H). Specifically, staff was trained on 8/20/15 to identify non-verbal indicators of pain such as facial expressions, vocalizations, body movements, changes in interpersonal interactions, changes in activity patterns, and mental status changes. To ensure this deficiency does not occur again, the Residential Manager, QDP, Nurse and Residential Coordinator will monitor the administration of medications through weekly, monthly and quarterly unannounced observations. **Residential Manager, QDP, Nurse, and Coordinator responsible.**	

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	administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders and the pharmacy instructions should be followed. On 8/5/15 at 1:00pm, 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 and the pharmacy instructions. On 8/5/15 at 8:50am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The agency nurse indicated client #6 should have been given 3-4 sprays into each nostril on 8/5/15. 9-3-6(a)			