

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G612	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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W 0000  Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 5/4, 5/5, 5/6, and 5/13/2016.</p> <p>Provider Number: 15G612 Facility Number: 001163 AIM Number: 100388230</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/19/16.</p>	W 0000		
W 0140  Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #2), the facility failed to ensure client #2 had a complete and accurate accounting of his personal client finance account.</p> <p>Findings include:  On 5/5/16 at 8:55am, an interview was</p>	W 0140	<p>Staff will be trained on Residential Financial Policy by June 12, 2016 All staff will sign off that they have been trained and understand the policy (attachment A) Staff will document all transactions in the petty cash log (attachment B) RM, QDP, and Coordinator will monitor through observations to ensure compliance (attachment C) Responsible staff: RM, QDP, and</p>	06/12/2016

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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	<p>conducted and client #2's personal financial account was audited with the Residential Manager (RM). The RM unlocked the safe box and removed client #2's two cash pouches. The RM counted client #2's cash on hand for his weekday cash and weekend cash. Both pouches balanced to the ledgers and receipts on hand. Inside the lock box was a loose wallet identified by the RM as belonging to client #2. The RM counted the money inside the wallet and indicated the wallet contained \$3.10 inside. The RM indicated the wallet did not contain a ledger sheet to indicate an accounting for client #2's third container of money. The RM indicated she would look into the third container of client #2's money.</p> <p>On 5/6/16 at 11:50am, an interview with the CSC (Community Services Coordinator) was completed. The CSC provided an undated written explanation from the RM regarding client #2's personal funds. The explanation indicated "When counting [client #2's] money there was an extra wallet. When I went back to the group home to figure this out, the day shift manager [GHS (Group Home Staff) #3] told me the wallet was [client #2's] for her shift. When she had taken [client #2] to [name of store], she knew his account was short so she put her money in [client #2's] petty</p>		Coordinator	

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	<p>cash to replace missing money on 4/13/16. This is why the account was over." This was signed by the RM.</p> <p>On 5/6/16 at 11:50am, the facility's 2/2015 "Residential Audit and Financial Procedures" indicated "...4.6. Cash on hand related to goals/objectives. 4.6.1. A petty cash ledger will be maintained by the person served for all cash on hand as it is outlined in the Individual Support Plan...4.6.4. Each home will keep a list of the people in their home that has a money goal and how much money that client receives...11.2. A ledger will be established for each person served. The ledger must be signed by the person served and the Residential Manager or designee any time a deposit is made or money is removed for day to day expenses...." The policy indicated a "complete and accurate" account including receipts, documentation of disbursements, and deposits were to be documented.</p> <p>On 5/13/16 at 8:30am, the CSC indicated no further information was available for review. The CSC indicated client #2's personal financial account did not have a complete and accurate account of his finances on 5/5/16.</p> <p>9-3-2(a)</p>			

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W 0159  Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION 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 reviewed 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 5/5/16 at 10:20am. Client #1's 3/15/15 ISP (Individual Support Plan) data was reviewed, and programs were monitored by a QIDP on 3/15/16, 1/16, 7/15, and 6/15. No QIDP 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 5/5/16 at 8:40am. Client #2's 8/27/15 ISP (Individual Support Plan) data was reviewed and programs were monitored by a QIDP on 4/16, 3/16, 2/16, 1/16, and 8/27/15. No QIDP reviews of client #2's programs were available for review for</p>			W 0159	<p>QDP (Qualified Developmental Professional) was trained on program monitoring and changes needed (attachment D) RM (Residential Manager), QDP, and Community Services Coordinator will monitor for updated paperwork in the home during monthly observations to ensure compliance (attachment C) 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. The Coordinator supervises the QDP and will ensure that we remain in compliance monthly by reviewing the paperwork Responsible parties: QDP, RM, and Coordinator</p>		05/27/2016

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	<p>9/15, 10/15, 11/15, and 12/15.</p> <p>Client #3's record was reviewed on 5/5/16 at 11:15am. Client #3's 12/23/15 ISP (Individual Support Plan) data was reviewed and programs were monitored by a QIDP on 4/16, 3/16, 2/16, 1/16, 12/23/15, and 6/2015. No QIDP reviews of client #3's programs were available for review for 8/15, 9/15, 10/15, and 11/15.</p> <p>Client #4's record was reviewed on 5/5/16 at 12noon. Client #4's 1/2016 ISP (Individual Support Plan) data was reviewed and programs were monitored by a QIDP on 4/16, 3/16, 2/16, and 1/16. No QIDP reviews of client #4's programs were available for review for 6/15, 7/15, 8/15, 9/15, 10/15, 11/15, and 12/15.</p> <p>On 5/5/16 at 9:35am, 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 for the period from 6/2015 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 oversight of the services were not completed by a QIDP. The CSC</p>						

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W 0317 Bldg. 00	<p>indicated the facility had an opening for a QIDP from 7/2015 until the 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(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 1 of 1 sampled client (client #1) who received psychotropic medications, the facility failed to evaluate client #1's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/5/16 at 10:20am. Client #1's 3/15/16 ISP (Individual Support Plan), 3/15/16 Self Management (Behavior) Plan (SMP), and 3/1/16 Physician's Orders indicated client #1 received "Luvox 250mg (milligrams) HS (at bedtime)" for behaviors of hair pulling,</p>	W 0317	QDP will ensure that the doctor reviews and initials at least yearly the decrease or contraindication of psychotropic medications. (attachment E) This will be reviewed at each annual case conference by the IDT The IDT will consist of guardian, consumer, QDP, RN, RM, Coordinator, and staff QDP, RM, and RN will review this information during their observations to ensure compliance (attachment C) Responsible Party: QDP, RM, and Coordinator	05/20/2016

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	<p>removing/pulling clothing, and loud vocalizations. Client #1's psychiatric medication reviews on 4/27/16, 3/1/16, 1/6/16, 11/11/15, 7/12/15, 5/27/15, 4/1/15, and 2/3/15 indicated the use of "Luvox 250mg" for the behaviors of hair pulling, removing/pulling clothing, and loud vocalizations. Client #1's behavior tracking documented on each of client #1's psychiatric medication reviews indicated "Luvox will be reduced by 50mg each time [client #1] meets... [Client #1] will continue to reduce hair pulling and eating of hair from 5 days a month to 0 (zero) days a month for 6 consecutive months," and client #1's behaviors of hair pulling had been at a zero rate for the months from 6/2014 through 1/2015 and from 4/2015 through 7/2015. Client #1's record indicated the last psychotropic medication change was not available for review. Client #1's record did not indicate a current year medication change or contraindication.</p> <p>Interview with the CSC (Community Services Coordinator), the agency Registered Nurse (RN), and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 5/13/16 at 8:30am. The CSC, the RN, and the QIDP indicated client #1's psychiatric medication had not been changed in over a year and no contraindication for client</p>			

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W 0368 Bldg. 00	<p>#1's psychiatric medication was available for review. The CSC indicated client #1's behavior of hair pulling had been at zero for the months from 6/2014 through 1/2015 and from 4/2015 through 7/2015. The CSC indicated there was no documentation that a medication change or a medication reduction had been considered available for review.</p> <p>9-3-5(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 4 sampled clients (clients #1, #2, and #4) and 1 additional client (client #8), the facility failed to ensure clients #1, #2, #4, and Discharged client #8's medications were administered according to physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports and investigative records from 1/1/16 through 5/4/16 were reviewed on 5/4/16 at 11:55am. The review included the following:</p>	W 0368	<p>Staff that made the med errors were retrained once the med error was found and per our policy staff completed an error free medication administration following all 6 rights while being supervised by the RM or RN. Staff were not allowed to pass medications unsupervised until this was completed successfully. (attachment F) The wellness nurse completed a training with staff on 5/13/16 at a house meeting. The training reviewed medication passes and the importance of the 6 rights of medication. (attachment G) All staff were required to take and pass the medication test by 05/01/2016.(attachment H ). Alarms have been set on the ipad to remind staff of medication</p>	05/27/2016

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	<p>For client #1:</p> <p>-A 3/24/16 BDDS report for an incident on 3/23/16 at 3:00pm indicated client #1's "Physician prescribed her to be given Tylenol and Ibuprofen alternating every 8 hours (for pain and discomfort). She was to be given the Tylenol at 3pm and the medication was not given."</p> <p>-A 3/17/16 BDDS report for an incident on 3/17/16 at 2:00pm indicated client #1 "was to be given a new med. (medication) order to get Tylenol two 325mg tablets every 8 hours to be alternated with Ibuprofen 200mg tablets every 8 hours (for pain and discomfort). Staff gave her Ibuprofen when it should of (sic) been Tylenol and the med. (medication) was not documented in the med book either."</p> <p>-A 2/7/16 BDDS report for an incident on 2/6/16 at 7:30am indicated "Staff gave [client #1] 2 (doses) 500mg (milligrams) Folitab (a multivitamin with iron for nutrition) when [client #1] should have received one."</p> <p>For client #2:</p> <p>-A 3/21/16 BDDS report for an incident on 3/21/16 at 8:00am indicated client #2 "was to get his Gabapentin (for nerve pain and anticonvulsant) 600mg at noon and the dose was not given."</p>		<p>times These will be kept updated by the RM and reviewed monthly during observations Staff will be monitored for compliance through increased observations by RM and Nurse (weekly each shift) until satisfied that home is in compliance and then return to regular schedule of observations. (attachment C) Responsible Party: Nurse, RM, Coordinator</p>	

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	<p>-A 2/10/16 BDDS report for an incident on 2/10/16 at 8:00am indicated "When taking out trash staff found a ripped open bag of trash hanging from a trash can. On the ground was (sic) several pills that had fallen out of the ripped bag and pork chop bones." The report indicated "It was determined that the medication was [client #2's] morning medications. [Client #2] did not receive his meds on 2/7/16. The staff admitted to accidentally dropping them into the trash can. Staff did not report this incident and instead signed that he had given [client #2] the medications. Staff has been terminated for concealing a medication error." The report did not identify the medications found in the trash.</p> <p>For client #4: -A 2/8/16 BDDS report for an incident on 2/6/16 at 7:30am indicated client #4's "Miralex (for constipation) was not given but documented" on client #4's 2/2016 MAR (Medication Administration Record. The report indicated "New bottles of Miralex were brought into the home on Friday by the pharmacy and old bottles were taken. When Monday morning medication pass occurred they (the staff) discovered that the seal had not been broken on the new bottles so the medication could not have been given."</p>			
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	<p>For discharged client #8: -A 2/16/16 BDDS report for an incident on 2/16/16 at 11:00am indicated discharged client #8 "was prescribed a new medication, Linzess (sic) (a medication used for the treatment of chronic idiopathic constipation and irritable bowel syndrome) after a stay in the hospital. Upon return there was a concern over the script that [name of staff] clarified with our agency nurse. [The Residential Manager (RM) name] failed to add new medication to the MAR (Medication Administration Record). This caused the med to not be given as ordered for 5 days."</p> <p>Client #1's record was reviewed on 5/5/16 at 10:20am. Client #1's 3/1/16 "Physician's Order" indicated "Folitam 500mg (a multivitamin with iron for nutrition) take one tablet by mouth every other day" and a 3/16/16 physician's order for "Tylenol 325mg and Ibuprofen alternating every 8 hours (for arthritis pain and discomfort)."</p> <p>Client #2's record was reviewed on 5/5/16 at 8:40am. Client #2's 3/1/16 "Physician's order" indicated "Gabapentin (for nerve pain and anticonvulsant) 600mg at noon" and client #2's morning medications ordered by his physician</p>			

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	<p>were "Vitamin D2 1.25mg/50,000 units (for nutrition), take one capsule by mouth every month on the fourth, Thera M (vitamin for nutrition) take one tablet by mouth daily, GNP Acidophilus 1.75mg capsule (to prevent the growth of bacteria), take one capsule by mouth every day, Gabapentin 600mg (for nerve pain and anticonvulsant), take one tablet by mouth three times daily, Calcium O.S. (Oyster Shell for nutrition), take one tablet by mouth twice daily, Dilantin 100mg (for seizures) , take two capsules by mouth twice daily (for seizures), and Primidone 250mg (an anticonvulsant), take one tablet by mouth twice daily."</p> <p>Client #4's record was reviewed on 5/5/16 at 12:00noon. Client #4's 3/1/16 "Physician's Order" indicated "Glycolax (also known as Miralax for constipation), mix one scoop or 17gm (grams) in eight ounces of fluid once a day."</p> <p>Discharged client #8's record was reviewed on 5/5/16 at 11:20am. Client #8's 3/1/16 "Physician's Order" indicated he was prescribed a new medication, "Linzess (sic) (a medication used for the treatment of chronic idiopathic constipation and irritable bowel syndrome) after being admitted to the hospital on 2/1/16 during a home visit with family and returned on</p>			

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	<p>approximately 2/10/16.</p> <p>On 5/5/16 at 9:35am, an interview with the CSC (Community Services Coordinator) and the agency nurse was conducted. The CSC and the agency nurse both indicated staff should ensure clients #1, #2, #4, and Discharged client #8's physician's orders were followed. The agency nurse indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration.</p> <p>On 5/5/16 at 11:45am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.</p> <p>On 5/13/16 at 3:15pm, the CSC indicated no further information was available for review.</p> <p>9-3-6(a)</p>						