STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G367	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL SERVICES INC OF INDIANA	1207 W WINONA AVE WARSAW, IN 46580

(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
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00185898. COMPLAINT #IN00185898: SUBSTANTIATED, Federal/state deficiencies related to the allegation(s) are cited at W149, W157 and W368. Dates of Survey: January 21, 22 and 25, 2016. Facility number: 000881 Provider number: 15G367 AIM number: 100249180 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/26/16.	W 0000		

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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	15G367		01/25/2016

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement policy and procedures which prohibited abuse, neglect and mistreatment by neglecting to protect 4 of 4 sampled clients (clients A, B, C and D) and 1 additional client (client F) from medication errors, and failed to implement client D's fall risk plan to prevent injury (sutures) as a result of a fall. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) from August, 2015 to January, 2016 were reviewed on 1/21/16 at 3:25 PM and indicated the following: 1. On 8/9/15 client B was given his 8:00 AM medications instead of his 8:00 PM medications. The report indicated staff was retrained to prevent additional medication errors. On 8/25/15 client D was not given Trileptal (oxcarbazepine 600 mg (milligrams) at 8:00 PM.	W 0149	**W149** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Per Cardinal Services, Inc. “Incident/Abuse/Neglect Policy,” Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. The support staff at the West Winona group home received additional training regarding this policy on 2/3/16 (see attachment A). All direct support staff working in the home were specifically trained on Client D’s Specialized Assistance Plan on 2/1/16 (see attachment B). All direct support staff working in the home were specifically trained on Medication Pass Procedures on 2/2/16 (see attachment C). Additionally, all direct support staff working in the home were specifically trained on Medication Check Procedures on 2/2/16 (see attachment D). All direct support staff working in the home	02/24/2016

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	On 9/28/15 client F was not given Vimpat (seizures). The report indicated staff was retrained to prevent additional medication errors. On 10/6/15 client A was given 400 mg Carbamazepine (seizures) instead of 200 mg. The report indicated staff was retrained to prevent additional medication errors. On 10/12/15 client F was not given Vimpat. The report indicated staff was retrained to prevent additional medication errors. On 11/4/15 it was discovered client D had not received his 8:00 AM dose of olanzapine (anti-psychotic) 20 mg (milligrams) on 11/3/15. The report indicated staff was retrained to prevent additional medication errors. On 11/18/15, client D was not given olanzapine as ordered. The report indicated staff was retrained to prevent additional medication errors. The Residential Coordinator was interviewed on 1/21/16 at 4:40 PM and indicated clients should be given medications without errors and staff had been retrained on medication errors.		completed and passed a Medication Error Competency Test on 2/2/16 (see attachments E). To ensure ongoing compliance with error free medication administration, implementation of all risk plans, and implementation of all policies and procedures the Residential Manager, Nurse, QDP, and Coordinator will monitor medication administration and implementation of all risk plans through weekly, monthly, and quarterly observations. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Coordinator, Manager, Nurse, and QDP Responsible**	

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	A BDDS report dated 7/28/15 was reviewed on 1/22/16 at 10:30 AM and indicated client B was given a double dose of Nexium (antacid). The report indicated staff was retrained to prevent additional medication errors. A BDDS report dated 4/14/15 was reviewed on 1/22/16 at 4:40 PM and indicated on 4/14/15 client F was not given 1,000 mg of Keppra (seizures) as ordered at 8:00 PM for 6 days and instead received 500 mg instead due to staff placing it in the wrong time slot for administration. The report indicated staff had been retrained on medication errors. Clients A, B, D and F's 11/15 physician's orders were reviewed on 1/22/16 at 4:59 PM and indicated the following: Client F was to receive Keppra 1,000 mg at 8:00 PM and Vimpat 200 mg twice daily. Client D was to receive Olanzapine 20 mg 1/2 tablet twice daily and oxcarbazepine 600 mg twice daily. Client B was to receive the following medications at 8:00 AM: haloperidol (anti-psychotic) 10 mg at 8:00 AM and 5:00 PM, oxcarbazepine (seizures) 150 mg at 8:00 AM and 8:00 PM,			

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	benztropine (side effects of medications) 0.5 mg at 8:00 AM and 8:00 PM, multivitamin (supplement) at 8:00 AM. Client A was to receive Carbamazepine 200 mg 1 and 1/2 tabs at 7:00 AM and 8:00 PM. A BDDS report dated 5/18/15 was reviewed on 1/25/16 at 11:50 AM and indicated client C received a double dose of Fluvoxamine 100 mg (depression) in the morning. The report indicated staff were retrained on medication administration procedures. Client C's 11/15 physician's orders were reviewed on 1/25/16 at 11:52 AM and indicated he was to receive Fluvoxamine 100 mg at 7:00 AM. The group home nurse was interviewed on 1/25/16 at 12:00 PM and indicated she retrained all staff after medication errors and a quality assurance meeting took place monthly to determine what caused medication errors to prevent future occurrence. 2. A report dated 10/17/15 indicated client D fell in his room causing 3 lacerations above his right eyebrow, combined length of 4 cm (centimeters). Client D was taken to the emergency			

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	room and received 7 sutures. A follow up report dated 10/23/15 indicated client D had a fall risk plan in place and staff would continue to monitor and report any changes. An investigation attached to the report dated 10/17/15 indicated a conclusion that client D's fall risk plan was not being followed at the time of the incident as he was not wearing his helmet as indicated in his plan. The Residential Coordinator was interviewed on 1/25/16 at 11:55 AM and indicated client D's plan to reduce injury from falls was not followed. Client D's fall risk plan dated 3/17/15 was reviewed on 1/25/16 at 11:55 AM and indicated client D was to use a helmet at all times except when showering. The facility's policy and procedures "Cardinal Services, Inc. Incident/Abuse/Neglect Policy Persons Served dated 3/15 was reviewed on 1/21/16 at 4:11 PM and indicated in part, "Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental sexual abuse, neglect or exploitation of person's served by staff members, other persons served, or others will not be tolerated; incidents			

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	will be reported and thoroughly investigated...." Neglect was defined as "Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his or her life or health...)." This federal tag relates to complaint #IN00185898. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed to protect 4 of 4	W 0157	W157	02/24/2016

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	sampled clients (clients A, B, C and D) and 1 additional client (client F) from medication errors. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) from August, 2015 to January, 2016 were reviewed on 1/21/16 at 3:25 PM and indicated the following: On 8/9/15 client B was given his 8:00 AM medications instead of his 8:00 PM medications. The report indicated staff was retrained to prevent additional medication errors. On 8/25/15 client D was not given Trileptal (oxycarbazepine 600 mg (milligrams) at 8:00 PM. On 9/28/15 client F was not given Vimpat (seizures). The report indicated staff was retrained to prevent additional medication errors. On 10/6/15 client A was given 400 mg Carbamazepine (seizures) instead of 200 mg. The report indicated staff was retrained to prevent additional medication errors. On 10/12/15 client F was not given		If the alleged violation is verified, appropriate corrective action must be taken. Per Cardinal Services, Inc. "Incident/Abuse/Neglect Policy," Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. The direct support staff at the West Winona group home received additional training regarding this policy on 2/2/16 (see attachment A). All direct support staff working in the home were trained on Medication Pass Procedures on 2/2/16 (see attachment C). Additionally, all direct support staff working in the home were trained on Medication Check Procedures on 2/2/16 (see attachment D). All direct support staff working in the home completed and passed a Medication Error Competency Test on 2/2/16 (see attachments E). To ensure ongoing compliance with error free medication administration, the Residential Manager, Nurse, QDP, and Coordinator will monitor medication administration through weekly, monthly, and quarterly observations. The Quality Assessment Analysis Team will monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses.	

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	Vimpat. The report indicated staff was retrained to prevent additional medication errors. On 11/4/15 it was discovered client D had not received his 8:00 AM dose of olanzapine 20 mg (milligrams) on 11/3/15. The report indicated staff was retrained to prevent additional medication errors. On 11/18/15, client D was not given olanzapine (anti-psychotic). The report indicated staff was retrained to prevent additional medication errors. The Residential Coordinator was interviewed on 1/21/16 at 4:40 PM and indicated clients should be given medications without errors and staff had been retrained on medication errors. A BDDS report dated 7/28/15 was reviewed on 1/22/16 at 10:30 AM and indicated client B was given a double dose of Nexium (antacid). The report indicated staff was retrained to prevent additional medication errors. A BDDS report dated 4/14/15 was reviewed on 1/22/16 at 4:40 PM and indicated on 4/14/15 client F was not given 1,000 mg of Keppra (seizures) as ordered at 8:00 PM for 6 days and instead		**Residential Manager, QDP, Nurse, Coordinator Responsible**	

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	received 500 mg instead due to staff placing it in the wrong time slot for administration. The report indicated staff had been retrained on medication errors. Client A, B, D and F's 11/15 physician's orders were reviewed on 1/22/16 at 4:59 PM and indicated the following: Client F was to receive Keppra 1,000 mg at 8:00 PM and Vimpat 200 mg twice daily. Client D was to receive Olanzapine 20 mg 1/2 tablet twice daily and oxcarbazepine 600 mg twice daily. Client B was to receive the following medications at 8:00 AM: haloperidol (anti-psychotic) 10 mg at 8:00 AM and 5:00 PM, oxcarbazepine (seizures) 150 mg at 8:00 AM and 8:00 PM, benztropine (side effects of medications) 0.5 mg at 8:00 AM and 8:00 PM, multivitamin (supplement) at 8:00 AM. Client A was to receive Carbamazepine 200 mg 1 and 1/2 tabs at 7:00 AM and 8:00 PM. A BDDS report dated 5/18/15 was reviewed on 1/25/16 at 11:50 AM and indicated client C received a double dose of Fluvoxamine 100 mg (depression) in			

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	the morning. The report indicated staff were retrained on medication administration procedures. Client C's 11/15 physician's orders were reviewed on 1/25/16 at 11:52 AM and indicated he was to receive Fluvoxamine 100 mg at 7:00 AM. The group home nurse was interviewed on 1/25/16 at 12:00 PM and indicated she retrained all staff after medication errors and a quality assurance meeting took place monthly to determine what caused medication errors to prevent future occurrence. This federal tag relates to complaint #IN00185898. 9-3-2(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION 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, the facility failed to ensure medications	W 0368	**W368**	02/24/2016

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	were administered in accordance to physician's orders for 4 of 4 sampled clients (clients A, B, C and D) and 1 additional client (client F). Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) from August, 2015 to January, 2016 were reviewed on 1/21/16 at 3:25 PM and indicated the following: On 8/9/15 client B was given his 8:00 AM medications instead of his 8:00 PM medications. The report indicated staff was retrained to prevent additional medication errors. On 8/25/15 client D was not given Trileptal (oxcarbazepine 600 mg (milligrams) at 8:00 PM. On 9/28/15 client F was not given Vimpat (seizures). The report indicated staff was retrained to prevent additional medication errors. On 10/6/15 client A was given 400 mg Carbamazepine (seizures) instead of 200 mg. The report indicated staff was retrained to prevent additional medication errors.		The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. 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. The support staff at the West Winona group home received additional training on Medication Pass Procedures on 2/2/16 (see attachment C). Additionally, all direct support staff working in the home were trained on Medication Check Procedures on 2/2/16 (see attachment C). All direct support staff working in the home completed and passed a Medication Error Competency Test on 2/2/16 (see attachments E). To ensure ongoing compliance with error free medication administration, the Residential Manager, Nurse, QDP, and Coordinator will monitor medication administration through weekly, monthly, and quarterly observations. The Quality Assessment Analysis Team will	

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	On 10/12/15 client F was not given Vimpat. The report indicated staff was retrained to prevent additional medication errors. On 11/4/15 it was discovered client D had not received his 8:00 AM dose of olanzapine 20 mg (milligrams) on 11/3/15. The report indicated staff was retrained to prevent additional medication errors. On 11/18/15, client D was not given olanzapine (anti-psychotic). The report indicated staff was retrained to prevent additional medication errors. The Residential Coordinator was interviewed on 1/21/16 at 4:40 PM and indicated clients should be given medications without errors and staff had been retrained on medication errors. A BDDS report dated 7/28/15 was reviewed on 1/22/16 at 10:30 AM and indicated client B was given a double dose of Nexium (antacid). The report indicated staff was retrained to prevent additional medication errors. A BDDS report dated 4/14/15 was reviewed on 1/22/16 at 4:40 PM and indicated on 4/14/15 client F was not given 1,000 mg of Keppra (seizures) as		monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential Manager, QDP, Nurse, Coordinator Responsible**	

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	ordered at 8:00 PM for 6 days and instead received 500 mg instead due to staff placing it in the wrong time slot for administration. The report indicated staff had been retrained on medication errors. Client A, B, D and F's 11/15 physician's orders were reviewed on 1/22/16 at 4:59 PM and indicated the following: Client F was to receive Keppra 1,000 mg at 8:00 PM and Vimpat 200 mg twice daily. Client D was to receive Olanzapine 20 mg 1/2 tablet twice daily and oxcarbazepine 600 mg twice daily. Client B was to receive the following medications at 8:00 AM: haloperidol (anti-psychotic) 10 mg at 8:00 AM and 5:00 PM, oxcarbazepine (seizures) 150 mg at 8:00 AM and 8:00 PM, benztropine (side effects of medications) 0.5 mg at 8:00 AM and 8:00 PM, multivitamin (supplement) at 8:00 AM. Client A was to receive Carbamazepine 200 mg 1 and 1/2 tabs at 7:00 AM and 8:00 PM. A BDDS report dated 5/18/15 was reviewed on 1/25/16 at 11:50 AM and indicated client C received a double dose			

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	of Fluvoxamine 100 mg (depression) in the morning. The report indicated staff were retrained on medication administration procedures. Client C's 11/15 physician's orders were reviewed on 1/25/16 at 11:52 AM and indicated he was to receive Fluvoxamine 100 mg at 7:00 AM. The group home nurse was interviewed on 1/25/16 at 12:00 PM and indicated she retrained all staff after medication errors and a quality assurance meeting took place monthly to determine what caused medication errors to prevent future occurrence. This federal tag relates to complaint #IN00185898. 9-3-6(a)			