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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G382 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>09/30/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>CARDINAL SERVICES INC OF INDIANA |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2347 W CR 350 S<br>WARSAW, IN46580                                     |                      |                                             |
| (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 |                                             |
| W0000                                                                | <p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: September 19, 20, 21, 22, and 30, 2011</p> <p>Surveyors:<br/>Susan Reichert, Medical Surveyor III-Team Leader<br/>Kathy J. Wanner, Medical Surveyor III</p> <p>Facility number: 000896<br/>Provider number: 15G382<br/>AIM number: 100235140</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/11/11 by Ruth Shackelford, Medical Surveyor III.</p> | W0000                                                           |                                                                                                                 |                      |                                             |

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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| W0218              | <p>The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on record review and interview, the facility failed to have 1 of 8 clients who lived in the home (client #5) to have an updated sensorimotor assessment after he had repeated falls.</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/19/2011 at 2:52 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 9/2010 and 9/19/11. The reports indicated the following:</p> <p>-a BDDS report dated 9/9/11 for an incident on 9/9/11 at 11:00 A.M. indicated client #5 lost his balance and fell into a peer's wheelchair, then landed on his back on the ground. Client #5 had a nickel sized abrasion to the middle of his back.</p> | W0218         | <p><b>350s Group Home Addendum POC</b></p> <p><b>W218</b><br/>The comprehensive functional assessment must include sensorimotor development.</p> <p>Cardinal is committed to providing quality individualized programming that includes assessment of sensorimotor development and implementation of needed interventions. Client #5 received a PT evaluation on 10-6-11 in which the therapist recommended 3 additional exercises, no additional assistive devices, and the continuation of gait belt/vest and helmet. (see attachment A) Interventions were developed to reflect the additional exercises. (see attachment B) Staff will be trained to implement new interventions by 11-7-11. (See attachment C) Mobility Screening/ Fall Plan was updated to reflect PT input. (See attachment D)</p> <p>The facility will ensure ongoing, assessment of sensorimotor needs through immediate review of accident/injury reports and</p> | 10/30/2011           |

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|                    | <p>-a BDDS report dated 8/24/11 for an incident on 8/23/11 at 9:55 A.M. indicated client #5 lost his balance and fell when a peer reached out to communicate to him. Client #5 fell backwards onto the peer and his wheelchair. Client #5 received a 2" (two inch) by 1/2" (one half inch) abrasion to the lower middle portion of his back.</p> <p>-an internal incident/accident report dated 7/11/11 at 7:45 A.M. indicated client #5 was "hurrying to get on the bus, " and fell forward scraping his left knee and arm. The description of the injuries was not available for review.</p> <p>-a BDDS report dated 3/10/11 for an incident on 3/10/11 at 2:15 P.M. indicated client #5 fell while he was walking, landing on the left side of his body. There was no note of injury.</p> <p>-a BDDS report dated 3/2/11 for an incident on 3/2/11 at 2:10 P.M.</p> |               | <p>incident reports by the Coordinator, monthly safety team analysis and periodic quality checks.</p> <p><b>QMRP, Residential Manager and Coordinator Responsible.</b></p> <p><b>W218</b> The comprehensive functional assessment must include sensorimotor development. Cardinal is committed to providing quality individualized programming that includes assessment of sensorimotor development and implementation of needed interventions. QMRP's were retrained to assess sensorimotor development and implement interventions on 10-21-11 (see attachment A). IDT re-evaluated client #5's need for a PT evaluation due to a pattern of falls. Client #5 was re-evaluated for physical therapy needs on 10-14-11, no additional recommendations were made by the PT DPT (see attachment B). QMRP's were re-trained to report falls resulting in injury on 10-19-11 (see attachment G). All accident reports will be reviewed by Coordinator (see attachment G). The facility will ensure ongoing, assessment of sensorimotor needs through immediate review of accident/injury reports and incident reports by the Coordinator, monthly safety team</p> |                      |

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|                                                                      | <p>indicated client #5 tripped over a chair and fell. Client #5 had a 2" by 1" abrasion to his left shoulder blade. Client #5 had a pea sized abrasion on the back of his right upper arm and a quarter sized bruise on the front of his right upper arm.</p> <p>Client #5's record was reviewed on 9/21/11 at 11:33 A.M. and indicated client #5 had a fall risk plan dated 8/23/11 which included the use of a helmet and a gait belt for staff to assist client #5 when ambulating. An Interdisciplinary Team (IDT) meeting dated 9/19/11 indicated the IDT had attempted trials of using a wheelchair, walker, and had ordered a padded vest for client #5 to wear due to most of his injuries being to his back. Client #5's record indicated he had physical therapy exercises. Client #5's record indicated his last PT evaluation was on 11/14/2005.</p> <p>The Qualified Mental Retardation Professional (QMRPD) was</p> |                                                                 | <p>analysis and periodic quality checks. <b>QMRP, Residential Manager and Coordinator Responsible.</b></p>      |                      |                                             |

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| W0318                                                                | <p>interviewed on 9/22/11 at 2:50 P.M.. When asked if client #5 had an updated sensorimotor evaluation, the QMRPD stated "We did not think it would be of any benefit since [client #5] has always been unsteady and has always fallen."</p> <p>9-3-4(a)</p> <p>The facility must ensure that specific health care services requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Health Care Services. The facility failed for 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8) to complete an updated sensorimotor assessment after a series of falls</p> | W0318                                                           | <p><b>W318</b> The facility must ensure that specific health care services requirements are met. Specific and sufficient health care services will be provided through the implementation of client specific protocols for identified areas of risk. Nurses and QMRP's were trained to identify areas of risk on 10-20-11 (see attachment A and C) Clients #1-8 were re-evaluated to determine the need for client specific</p> | 10/30/2011           |                                             |

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|                                                                      | <p>(client #5), failed to develop client specific protocols in accordance with identified needs of pneumonia, dysphagia, aspiration, choking, and hypoglycemia (clients #1, #2, #3 and #6), failed to make a referral to a physician for client #1 who had frequent elevated blood pressure, and by failing to have an RN on staff or available for consult for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>1. Please refer to W218. The facility failed to obtain an updated sensorimotor assessment for 1 of 8 clients who lived in the home (client #5) after he had repeated falls.</p> <p>2. Please refer to W331. The LPN failed to establish client specific protocols for 4 of 8 clients who lived in the home (clients #1, #2, #3 and #6) in accordance with their identified medical needs.</p> <p>3. Please refer to W338. The</p> |                                                                 | <p>protocols on 10-19-11 (see attachment D). Client specific protocols will be developed and implemented for each person with identified risk by October 30, 2011. To ensure ongoing compliance, Residential Manager will review documentation weekly, QMRP will review documentation monthly and Nurse will review documentation as per doctor's orders, at least monthly.<br/><b>Coordinator, Manager and Nurse Responsible.</b></p> |                      |                                             |

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| W0331              | <p>facility LPN failed to refer 1 of 4 sampled clients (client #1) to his physician for recurrent elevated blood pressure (BP) levels.</p> <p>4. Please refer to W346. The facility failed for 8 of 8 clients who lived in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8) to have a Registered Nurse (RN) on staff or to have a formal arrangement with an RN to be available for verbal or onsite consultations to the LPNs.</p> <p>9-3-6(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the LPN (licensed practical nurse) failed to establish</p> | W0331         | <p><b>W331</b> The facility must provide clients with nursing services in accordance with their needs. Nursing services will be provided in accordance with client needs as specified in each client's program plans, risk plans and</p> | 10/30/2011           |

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|                                                                      | <p>client specific protocols for 4 of 8 clients who lived in the home (clients #1, #2, #3 and #6) in accordance with their medical needs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/21/11 at 11:57 A.M.. Client #1's record indicated his blood pressure (BP) was often elevated. There was no BP protocol available for review to indicate when the staff should contact the LPN. Client #1's record indicated he had a choking plan/dysphagia plan dated 1/10/11 and he was classified as "high risk." There was no client specific protocol available for review to indicate the signs and symptoms staff should monitor for and to indicate when staff should notify the LPN.</p> <p>Client #2's record was reviewed on 9/21/11 at 3:35 P.M.. Client #2's record indicated he had a history of pneumonia, dysphagia/choking</p> |                                                                 | <p>health care plans. Specific and sufficient health care services will be provided through the implementation of client specific protocols for identified areas of risk. Physical Assessment Tool was revised to include parameters for BP, pulse, weight and temperature. (See attachment E). Nurses and staff were retrained on the new tool and guidelines of when to notify the nurse on 10-11. (see attachment E). Nurses and QMRP's were trained on identifying areas of risk on 10-19-11 (see attachment E). Client specific protocols will be developed and implemented for each person with identified risk by October 30 th , 2011 To ensure ongoing compliance, Residential Manager will review documentation weekly, QMRP will review documentation monthly and Nurse will review documentation as per doctor's orders and monthly.<br/><b>Coordinator, Nurse, QMRP and Manager Responsible.</b></p> |                      |                                             |

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|                                                                      | <p>with a plan dated 1/4/11, and was classified as a "slight risk," and had a diagnosis of hypoglycemia. There was no client specific protocol available for review to indicate the signs and symptoms of pneumonia, dysphagia, or hypoglycemia to indicate the signs and symptoms the staff should monitor for and to indicate when they should notify the LPN.</p> <p>Client #3's record was reviewed on 9/22/11 at 12:20 P.M.. Client #3's record indicated he was a "moderate risk" for choking. Client #3's record indicated he had a dysphagia/choking plan dated 8/16/11. There was no client specific protocol available to indicate the signs and symptoms of dysphagia, and to indicate when the staff should notify the LPN.</p> <p>Client #6's record was reviewed on 9/21/11 at 11:02 A.M.. Client #6's record indicated he choking plan dated 7/14/11. There was no client specific protocol available for</p> |                                                                 |                                                                                                                 |                      |                                             |

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|                                                                      | <p>review to indicate when staff should notify the nurse if client #6 choked.</p> <p>The LPN was interviewed on 9/22/11 at 2:30 PM and indicated there were no individualized protocols developed to address client specific risks of pneumonia, aspiration or high blood pressure. She indicated all staff were given generalized training and were to apply the training to all clients in their care.</p> <p>9-3-6(a)</p> |                                                                 |                                                                                                                 |                      |                                             |
| W0338                                                                | <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).</p> <p>Based on record review and</p>                                                                                                                                     | W0338                                                           | <p><b>W338</b> Nursing services must include, for those clients certified</p>                                   | 10/30/2011           |                                             |

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|                                                                      | <p>interview, the facility LPN failed to refer 1 of 4 sampled clients (client #1) to his physician for recurrent elevated blood pressure (BP) levels.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/21/11 at 11:57 A.M.. Client #1's record indicated the following:<br/>Nursing notes, 8/2011 BP 148/90, 6/2011 BP 138/90, 5/2011 BP 163/91, 4/2011 BP 136/91, 1/2011 BP 172/94 recheck 142/90, 12/2010 BP 166/114, 11/2010 BP 139/73.<br/>The nursing notes indicated "No areas of concern." The notes were signed and dated by the LPN each month. There was no documentation available for review to indicate the LPN had notified client #1's physician about his elevated BPs.</p> <p>The LPN was interviewed on 9/22/11 at 4:02 P.M.. The LPN stated "The nursing notes are completed each month by the staff at the group home. I do sign off on</p> |                                                                 | <p>as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). Nursing services for clients certified as not needing a medical care plan will be provided services in accordance with their needs, including referral to a doctor as needed. The Physical Assessment Tool was revised to include parameters for BP, pulse, weight and temperature. (See attachment E). Nurses and QMRPs were retrained on the new tool and guidelines of when to notify the nurse on 10-19-11. (see attachment E) To ensure ongoing compliance, Residential Manager will review documentation weekly and Nurse will review documentation as per doctor's orders and monthly. Coordinator will review documentation quarterly.<br/><b>Coordinator, Nurse, and Manager Responsible.</b></p> |                      |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G382 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>09/30/2011 |
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|                                                                      | <p>them. They are not good at taking manual BP's and the automatic cuff does not always give accurate readings. If the reading is high I have them recheck it."</p> <p>A review of the American Heart Association (AHA) web site guidelines for BP/HTN was conducted on 9/29/11 at 2:24 P.M..The AHA indicated the following; "Blood Pressure is normal (less than 120 mm (millimeters of mercury) Hg systolic (pressure in arteries when the heart beats) and less than 80 mm Hg diastolic (pressure in arteries between heart beats)... If BP numbers rise above 180/or 110, you need emergency treatment."</p> <p>9-3-6(a)</p> |                                                                 |                                                                                                                 |                      |                                             |

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| W0346                                                                | <p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on record review and interview, for 8 of 8 clients who lived in the home (Clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to have a Registered Nurse (RN) on staff or to have a formal arrangement with an RN to be available for verbal or onsite consultations to the LPNs (licensed practical nurse).</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/19/11 at 2:52 P.M. including Bureau of Developmental Disabilities Services (BDDS) reports and Incident/Accident reports. There was no indication the facility had an RN on staff to provide consultation regarding clients #1, #2, #3, #4, #5, #6, #7 and #8 medical needs.</p> | W0346                                                           | <p><b>W346</b> If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse. Cardinal Services has a formal arrangement with the Registered Nurse who works in the WIC Department of Cardinal Services. She is available for verbal or onsite consultation. (see attachment F) To ensure ongoing compliance, Director will maintain formal agreement with the WIC RN. <b>Director and Nurse Responsible.</b></p> | 10/30/2011           |                                             |

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| W9999              | <p>The facility Residential Director was interviewed on 9/19/11 at 4:22 P.M.. The RD stated the facility had "No RN on staff or as a consultant."</p> <p>9-3-6(a)</p> <p>State Findings</p> <p>460 IAC 9-3-1 Governing body<br/>Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 8 incident accident internal reports to report a fall resulting in injury to client #5 immediately to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law.</p> | W9999         | <p>W9999 The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. Cardinal Services Inc.'s Incident/Abuse/Neglect policy is currently in place to ensure that all allegations of neglect, abuse as well as significant injuries and medication errors are reported to the appropriate administer and BDDS timely. On 10/19/2011 Qualified Disability Professionals (QDP's) were retrained on revised Incident Reporting guidelines that became effective 03/01/2011. (see attachment G) These guidelines include reporting all falls that result in injury and all medication errors with the exception of documentation errors. By 10/23/2011 all Direct Support</p> | 10/23/2011           |

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|                                                                      | <p>Findings include:</p> <p>The facility records were reviewed on 9/19/11 at 2:52 P.M., BDDS Reports and internal incident and accident reports for the time period between 9/2010 and 9/19/11 indicated:</p> <p>-an internal incident/accident report dated 7/11/11 at 7:45 A.M. indicated client #5 was "hurrying to get on the bus,"and fell forward scraping his left knee and arm. The description of the injuries was not available for review. There was no BDDS report available for review.</p> <p>An interview with the facility's Residential Director (RD) on 9/20/11 at 4:37 P.M., When asked about the fall with injury not being reported, the RD stated, "It should have been reported."</p> <p>9-3-1(b)</p> |                                                                 | <p>Professionals will be re-trained on revised Incident Reporting guidelines that became effective 03/01/2011. These guidelines include reporting all falls that result in injury and all medication errors with the exception of documentation errors. Cardinal Services Inc. of Indiana requires Direct Support Professionals to report minor injuries that do not meet the BDDS reporting guidelines by use of the ACCIDNET/INJURY REPORT. The instructions on this form were revised to direct Direct Support Professionals to email a copy of the report to Residential Coordinators for review on 10/20/2011. (see attachment G) Direct Support Professionals will be trained by 10/23/2011 to submit a copy of all the ACCIDENT/INJURY REPORT to Residential Coordinators for review to insure that reportable incidents are not mistakenly reported as accidents or minor injuries. The Residential Coordinator and QDP will review all ACCIDENT/INJURY REPORTS to ensure accurate and timely reporting and to ensure this deficiency does not occur in the future. <b>Residential Coordinator and QDP Responsible</b></p> |                      |                                             |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2011

FORM APPROVED

OMB NO. 0938-0391

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