

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G651		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 628 ROSS AVE WARSAW, IN 46580			
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: December 12, 13, 16 and 17, 2013.</p> <p>Facility number: 001181 Provider number: 15G651 AIM number: 100234730</p> <p>Surveyor: Kathy Wanner, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/19/13 by Ruth Shackelford, QIDP.</p>			W000000			

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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W000149	<p>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 for 1 of 4 sampled clients (client #2), the facility failed to ensure staff implemented the agency's policy to protect individuals from potential harm by leaving client #2 unsupervised while in a vehicle for 1 of 32 Bureau of Developmental Disabilities Services (BDDS) reports reviewed.</p> <p>Findings include:</p> <p>Facility records were reviewed on 12/12/13 at 4:08 P.M. including the BDDS reports for the time frame between 12/12/12 and 12/12/13.</p> <p>-A BDDS report dated 4/26/13 for an incident on 4/25/13 at 11:00 A.M. indicated "...[client #2] reported that while he was waiting for staff in their car he accidentally hit the manual (clutch driven) gear shift and the car began to roll backwards. [Client #2] reported the car was not running and the keys were not in the car. The car was parked in the group home driveway. Staff observed the car rolling backwards and immediately went to the car and was able to stop the car at the end of the drive. The car did not go into the street. Upon investigation staff</p>	W000149	<p>W149</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Cardinal Services takes our responsibility to ensure for the safety of those we support seriously. When</p> <p>Client # 2 reported that he had been left unsupervised in a staff</p>	12/31/2013			

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	<p>reported that as she and [client #2] got into the car she (staff) suddenly became ill and had to immediately go inside the house to use the restroom. She removed the keys from the car to ensure for [client #2's] safety but did not think to apply the emergency brake. She stated she was in the house for approximately two minutes. [Client #2] does not require continuous one-on-one supervision and can be outside of his home on his property without staff. [Client #2] often becomes excited and anxious when leaving his home and will typically wait for staff and peers in the group home van. Staff received immediate training stating that they may not allow [client #2] or his peers to be in a vehicle without staff supervision. In addition, to ensure that this type of incident does not occur in the future, all staff will receive training advising them that they may not leave people we support unattended in vehicles."</p> <p>The facility's investigation dated 4/25/13 was reviewed on 12/16/13 at 11:15 A.M. and indicated in client #2's statement "People are leaving me in cars by myself, my moms (sic) not even allowed to do that. They leave me in cars when they go to get something, like they leave me in the car when they get gas. They leave me in the car with myself with another client...."</p>		<p>member's vehicle an immediate investigation was begun that substantiated Client #2's complaint. As a result staff responsible for leaving Client #2 in her vehicle on April 25, 2013 received counseling and additional training stating that she will not allow the people that she supports to be in any vehicle without staff supervision on May 2, 2013. (See Attachment A) Staff in the Ross Avenue group home received training stating that staff will not allow the people they support to be in any vehicle without staff supervision by May 7, 2013. (See Attachment B) To assure that no one receiving Residential Services with Cardinal Services would be left in any vehicle unsupervised all staff received this same training by May 10, 2013. (See Attachment B) There have been no</p>				

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	<p>One time at [store name] they left me in the car with the wipers on during a rainstorm....She turned the car off and left me to go get something. The car started rolling backwards. (I was) screaming for help. [Name of staff] stopped the car before it ran out into the street...it's that stupid shift. I didn't do it on purpose it was an accident. I was trying to tell [name of staff] that her car was moving somehow."</p> <p>Staff training documentation was reviewed on 12/16/13 at 11:15 A.M. The documentation indicated staff were trained on 5/2/13 regarding not allowing people they support to be in any vehicle without staff supervision and to teach people who are accustomed to being able to wait in the van/staff vehicle unsupervised that they may no longer do this.</p> <p>The facility's Incident/Abuse/Neglect Policy dated 2013-2014 was reviewed on 12/16/13 at 3:49 P.M. and indicated "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 persons served by staff members, other persons served, or others will not be tolerated; incidents will be reported and thoroughly investigated</p>		<p>additional incidents of staff leaving people they support unsupervised since this training.</p> <p>To assure ongoing compliance and to ensure that this deficiency does not occur again the Residential Manager, QDP, Support Services</p> <p>Coordinator and Residential Coordinator will complete weekly, monthly and quarterly unannounced observations.</p> <p>QMRP, Residential Manager, Support Services Coordinator and Residential Coordinator Responsible.</p>				

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	<p>as outlined in this policy. 2.4 Neglect: Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support, including food, drink, clothing, shelter, sleep, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities)."</p> <p>The Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed on 12/16/13 at 2:58 P.M.. When asked about the clients being unsupervised on vehicles, the QIDPD stated, "Staff should not leave the clients alone in vehicles."</p> <p>The Residential Manager (RM) was interviewed on 12/16/13 at 2:50 P.M. When asked if staff should leave clients alone on vehicles, the RM stated, "They all received training on this. It is not Cardinal's practice. We trained all the Cardinal staff after this incident to ensure clients were not being left unattended."</p> <p>9-3-2(a)</p>						

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	<p>from the missed dosage. Staff will receive training from the residential nurse on the correct procedure of passing medications. The staff responsible for not passing the correct dosage will be observed passing medication by the residential nurse and the RM for competency before passing medications."</p> <p>The investigation documentation dated 5/20/13 was reviewed on 12/16/13 at 11:15 A.M. indicated "[Client #4] received 1 pill not 2 of his Topiramate 200mg and Niacin 500mg from 5/14/13-5/18/13."</p> <p>Client #4's PO dated 10/28/13 was reviewed on 12/13/13 at 8:55 AM. The PO indicated client #4 was prescribed Topiramate 200mg take 2 tablets by mouth 2 times a day for organic mood/intermittent explosive disorder and Niacin 500mg take 2 tablets by mouth 2 times a day to improve lipid ratios.</p> <p>The facility LPN was interviewed on 12/16/13 at 2:19 P. M When asked if client #4 had received his medications correctly the LPN stated, "Not according to the MAR (medication administration record) or the physician's orders."</p> <p>9-3-6(a)</p>		<p>Avenue group home received training regarding an additional procedure</p> <p>implemented to prevent medication errors by November 9, 2013. (See attachment C)</p> <p>There have not been any additional medication errors in the Ross Avenue group</p> <p>home since the implementation of this procedure. To ensure that medication</p> <p>errors were reduced throughout the Residential Program, all Residential staff</p> <p>received training regarding this additional procedure by November 9, 2013. (See attachment C)</p> <p>To ensure this deficiency</p> <p>does not occur again, the Residential Manager, QDP, Nurse and Residential</p>				

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			<p>Coordinator will monitor the administration of medications through weekly, monthly and quarterly unannounced observations. (See attachment D)</p> <p>Residential Manager, Nurse, QDP and Residential Coordinator Responsible.</p>		

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