

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2016
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST WARSAW, IN 46580
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W 0000 Bldg. 00	<p>This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00191198.</p> <p>Complaint #IN00191198: SUBSTANTIATED, Federal and State deficiency related to the allegation is cited at W149.</p> <p>Dates of Survey: 1/12, 1/13, 1/14, 1/19, 1/20, 1/25, and 1/26/2016.</p> <p>Facility Number: 001050 Provider Number: 15G536 AIM Number: 100245380</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed 1/29/16 by #09182.</p>	W 0000		
W 0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS			

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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Bldg. 00	<p>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 1 fall with fractures (client A) for 1 of 4 sampled clients (client A), the facility neglected to ensure staff supervised and followed recommended safety interventions while client A was assisted to exit the facility van using the hydraulic lift.</p> <p>Findings include:</p> <p>On 1/19/16 at 10:30am, the Residential Coordinator (RC) provided review of an additional BDDS (Bureau of Developmental Disabilities Services) report for client A.</p> <p>-A 1/14/16 BDDS report for an incident on 1/14/16 at 3:30pm indicated client A "returned from a medical appointment (to the facility) and staff was assisting her onto the van lift so [client A] could exit the van." The report indicated "Staff positioned [client A] onto the van lift and locked the brakes on [client A's] wheelchair." The report indicated another staff was in her car arriving for work, looked up, and "saw [client A] and the other staff on the ground," the second staff "ran" into the group home, called 9-1-1, and both the staff person and client</p>	W 0149	<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>Per "Incident/Abuse/Neglect Policy Persons Served" Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. All direct support staff working at the Glad Street group home received training on the Incident/Abuse/Neglect Policy on 2/8/16 (see attachment A). Specifically all direct support staff demonstrated competency on utilizing the van wheel chairlift during Glad Street's house meeting on 1/25/16 (see attachments B). All direct support staff in Adult Services will receive training on the operation of Van/Bus wheel chair lifts by February 25, 2016. All Adult Services staff will demonstrate competency in operating the van/bus wheel chair lift yearly. To ensure this deficiency does not occur again ongoing monitoring will occur to ensure consistent implementation through weekly, monthly, and quarterly written observations by QMRP, Residential Manager, and Coordinator.</p> <p>Coordinator, Manager and</p>	02/25/2016

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	<p>A were transported to the hospital by ambulance. The BDDS report indicated client A's right shoulder, clavicle, and arm were injured and X-Rayed. The BDDS report indicated client A had fractures to her right Clavicle (the collarbone is located between the ribcage and the shoulder blade and connects the arm to the body) and right Humerus bone (the long bone in the upper arm) in her arm.</p> <p>-A 1/14/16 "Investigation" indicated client A and a staff person "fell off the lift" to the facility van on 1/14/16 at "approximately 3:30pm" after the staff member had "positioned" client A's wheelchair onto the lift. The investigation indicated the following:</p> <p>-An undated witness statement from the "Fire Department/Fire Chief" indicated he "inspected the lift upon arrival (to the group home). [The Fire Chief] did not note anything that would have caused the lift to malfunction....He stated that it appeared that when [client A's] (wheel) chair was placed on the van lift that [client A's wheel chair] was likely not all the way on the lift and that part of [client A's] chair was still on the platform. He suggested that the staff went to lower [client A] and [client A] likely started to tip due to being partly on the platform as</p>		QDPs Responsible				

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	<p>(the lift) was lowering. Staff noticed that [client A] was starting to tip and attempted to grab [client A's wheelchair] which resulted in the staff losing their balance and toppling on top of [client A] as the chair was falling. The control was still in staff's hand as they were falling the force likely caused staff to continue pushing the button on the way down."</p> <p>-Client A's witness statement indicated client A "stated she was getting off the bus and the light was red. [Staff name] pushed her onto the lift and then did a somersault" and client A indicated the staff was not on the lift when client A was lowered.</p> <p>-The investigation "Conclusion" was "...it was concluded that the most probable cause for this incident was [client A] was not properly placed onto the van lift prior to staff lowering the lift, [client A] being partially on the lift and partially on the platform (of the facility van) this would indicate why [client A] saw a red light on the lift in the on position...As staff went to lower [client A] she began to tip and staff attempted to grab her resulting in staff losing her balance and falling forward with [client A]. The lift was lowered during this incident as the control for the lift was still in the staff's hand at the time she fell. It is contrary to</p>			

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	<p>Cardinal Service's policy to lower a consumer on the van lift while the staff is (sic) inside the van. Staff is trained to push the consumer to the yellow line on the inside of the van and then exit the van and finish pulling the consumer onto the van lift and to never lower the consumer while staff is on the inside of the van."</p> <p>On 1/26/16 at 9:12am, an interview was conducted with the RC (Residential Coordinator). The RC indicated the facility followed the BDDS guidelines for abuse, neglect, and/or mistreatment. The RC indicated client A used a wheelchair because client A was at risk to fall. The RC indicated the facility staff person neglected to supervise client A correctly while client A was in her wheelchair and on the van lift. The RC stated client A's "Incident was neglect" by the staff not following the agency safety protocols before operating the lift with client A. The RC indicated no staff operated the van lift until after retraining was completed after the 1/14/16 incident. The RC indicated staff were trained annually and immediately after the incident for safety on the van.</p> <p>On 1/12/16 at 1:00pm, the facility's 7/2012 "Incident/Abuse/Neglect Policy" was reviewed. The policy indicated "Cardinal Services Inc. is committed to</p>			

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	<p>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 (sic); incidents will be reported and thoroughly investigated as outlined in this policy...1.13 Injuries of unknown origin where the injury could be indicative of abuse, neglect, or exploitation or requires medical evaluation or treatment...."</p> <p>On 1/12/16 at 1:00pm, the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p>			

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W 0331 Bldg. 00	<p>This federal tag relates to complaint #IN00191198.</p> <p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>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 D), the facility's nursing services failed to develop protocols specific to client D to monitor and to manage his pain.</p> <p>Findings include:</p> <p>On 1/13/16 at 4:15pm, GHS (Group Home Staff) #1 asked client D to come to the medication closet at the group home. GHS #1 selected client D's pain medication "Tylenol 325mg (milligrams) two (2) tablets every 4 hours as needed for pain." GHS #1 placed two tablets into a souffle cup, then into apple sauce, and fed the medication to client D. GHS #1 indicated client D was non verbal, was</p>	W 0331	<p>W331</p> <p>The facility must provide clients with nursingservices in accordance with their needs. The Residential Nurses received training regarding thedevelopment of client specific care plans on 2/9/16 (see attachment E). The nurseprovided training on Pain Management Instructions and Information for PainTracking from the Med Manual on 8/24/15 (see attachments C & D). In addition the nurse provided training to all staff working in the home onThrush, Thorough Hand Washing, and Universal precautions on 12/10/15 (seeattachments N). An initial pain management assessment was implemented forClient D on 11/28/15 and completed through 1/17/16 (see attachments F).</p>	02/25/2016			

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	<p>not asked questions regarding his pain/discomfort, and stated "We (the staff) just know" when client D had pain/discomfort. GHS #1 indicated client D's pain medication was administered for dental discomfort. At 4:15pm, client D's 1/2016 MAR (Medication Administration Record) indicated "Acetaminophen 325mg (milligrams) 2 tablets every 4 hours as needed for pain, Ibuprofen 800mg take 1 tab 3 x (times) per day as needed for pain inflammation of teeth, gingivitis, + (and) thrush (an infection of the mouth) 1/12/16 hold until dental surgery, (and) Norco take 1 or 2 tablets PO (by mouth) every 6 hrs. (hours) as needed for pain." Client D's 1/2016 MAR indicated he was receiving pain medications every four hours for dental pain for the month.</p> <p>Client D's record was reviewed on 1/14/16 at 12:00pm and on 1/25/16 at 2:00pm. Client D's 12/2015 Physician's Order indicated "Acetaminophen 325mg (milligrams) 2 tablets every 4 hours as needed for pain, Ibuprofen 800mg take 1 tab 3 x (times) per day as needed for pain inflammation of teeth, gingivitis, + (and) thrush (an infection of the mouth)." Client D's 11/20/15, 12/9/15, and 12/29/15 Dental assessments indicated client D had mouth pain "D/T (Due To) Gingivitis and Thrush." Client D's record</p>		<p>ClientD's MARS indicate he was receiving his PRN medication for pain and theeffectiveness was being documented (see attachments G). Client D had hisscheduled dental appointment on 1/18/16 to have his remaining teeth removed.Since having his teeth removed Client D has not had any symptoms of pain andhas resumed normal activities without incident. Staff received additionaltraining on Pain Management Instructions on 2/8/16 (see attachment H). To ensure this deficiency does not occur in thefuture, the Coordinator will monitor care plans for thoroughness in amendmentsthrough documentation review and internal audits. Spot checks will be completedby the Coordinator monthly and each time a new care plan is implemented it willbe reviewed for thoroughness and accuracy. The Residential Manager, QDP, andCoordinator will ensure ongoing compliance through weekly, monthly andquarterly observations.</p> <p>Coordinator, Residential Nurse, QDP, and Residential Manager responsible</p>	

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	<p>indicated he was non verbal and used gestures/pointing to communicate his wants/needs. Client D's record did not indicate a pain assessment available for review. No information was available for review to determine if client D's pain medication was effective and no information was available for review to determine if the pain medication was effective to control client D's pain. No guidelines or protocols for client D's pain were available for review.</p> <p>On 1/13/16 at 11:00am, an interview with the agency Licensed Practical Nurse (LPN), the Residential Coordinator (RC), and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The LPN indicated client D had physician's orders for as needed pain medications and should receive the pain medication when client D appeared to be in pain/discomfort. The LPN and the RC both stated "No, [client D] did not have a completed pain assessment" available for review. The LPN indicated client D had been scheduled for dental surgery and had blisters and "Thrush" reappearing inside his mouth from a dental infection. The LPN indicated the facility followed Core A/Core B Living in the Community policy and procedure for medication administration.</p>			

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W 0391 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 of 3 medications administered in the morning (for client H), the facility failed to remove from use the medication containers without labels from the supply.</p> <p>Findings include:</p> <p>On 1/14/16 at 7:25am, GHS (Group Home Staff) #2 asked client H to come to the medication closet at the group home. GHS #2 selected client H's unlabeled "Levemir Injection Flex" Pen, attached a disposable needle on the end of the pen, and set the unit administration dial on the pen to 34 units. GHS #2 asked client H to count with her "1-2-3, poke," and GHS #2 inserted the unlabeled medication pen into client H's arm which administered 34 units. At 7:35am, GHS #2 stated "No, the Levemir Flex" pen did not have a pharmacy label to indicate client H's name, directions for the medication use, and the medication</p>	W 0391	<p>W391</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels. Cardinal Services, Inc. has in effect procedures to assure safe and responsible administration of prescriptions and non-prescription medications, as well as tracking process to provide training and discipline for non-compliance. A label for Client H's medication was obtained from the Pharmacy on 1/14/16. All staff working directly with Client H received additional training on Labeling of medications on 2/8/16 (see attachment I). All direct support staff working in the home received additional training on Medication Pass Procedures on 2/8/16 (see attachment J). To ensure this deficiency does not occur again ongoing monitoring will occur to ensure consistent implementation through weekly, monthly, and quarterly written observations by QMRP, Residential Manager, and Coordinator.</p> <p>QMRP, Residential Manager, and Coordinator Responsible</p>	02/25/2016			

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	<p>information. At 7:35am, client H's 1/2016 MAR (Medication Administration Record) indicated "Levemir Inj (Injection) FlexTouch (Pen), inject 34 units subcutaneous once daily for Diabetes."</p> <p>On 1/25/16 at 2:30pm, client H's 11/2/15 Physician's Orders indicated "Levemir Inj (Injection) FlexTouch (Pen), inject 34 units subcutaneous once daily for Diabetes."</p> <p>On 1/13/16 at 11:00am, an interview with the agency Licensed Practical Nurse (LPN), the Residential Coordinator (RC), and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RC and LPN both indicated the facility followed Core A/Core B medication administration training for medication administration. The LPN indicated each medication should have a pharmacy label which could be read including: the client's name, name of the medication, dosage, and directions for the medication's use.</p> <p>On 1/13/16 at 11:00am, a record review was conducted of the facility's undated policy and procedure "Medication Administration." The policy and procedure indicated the facility followed Core A/Core B Living in the Community</p>			

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W 0436 Bldg. 00	<p>for medication administration.</p> <p>On 1/13/16 at 11:00am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients observed (client A) with adaptive equipment, the facility failed to have client A's prescribed eye glasses available and encouraged client A to wear her prescribed eye glasses when opportunities existed.</p> <p>Findings include:</p> <p>On 1/13/16 from 12:40pm until 5:35pm and on 1/14/16 from 7:00am until 8:35am, observation of client A was</p>	W 0436	<p>W436</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces and other devices identified by the interdisciplinary team as needed by the client.</p> <p>An informal goal was implemented on 2/9/16 for Client A to be encouraged to wear her eye glasses as prescribed by her Optometrist (see attachment K). All direct support staff working directly in the home</p>	02/25/2016			

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	<p>conducted at the group home and client A was not prompted and encouraged to wear her prescribed eye glasses. During both observation periods client A watched television, completed medication administration, set the dining room table for meals, read a magazine, completed word find puzzles, played bingo, and was not encouraged to wear her prescribed eye glasses.</p> <p>Client A's record was reviewed on 1/14/16 at 1:35pm. Client A's 4/21/15 ISP (Individual Support Plan) did not indicate a goal to wear her prescribed eye glasses. Client A's ISP did not indicate client A wore prescribed eye glasses. client A's 3/31/15 Visual examination indicated "needs glasses...new Bifocal Glasses today."</p> <p>On 1/14/16 at 1:50pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client A should be encouraged to wear her prescribed eye glasses to see. The QIDP indicated client A wore prescribed eye glasses.</p> <p>9-3-7(a)</p>		<p>received training in regards to Client A being encouraged to wear her eye glasses and providing training on the importance of wearing them on 2/8/16 (see attachment L). Client A's ISP was updated on 2/9/16 to reflect her use of eye glasses (see attachment M). To ensure this deficiency does not occur again, the Residential Manager, QDP, and Residential Coordinator will monitor the implementation of Client A's use of eye glasses through weekly, monthly, and quarterly observations. Residential Manager, QDP, and Coordinator responsible</p>		