

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 09/30/2011
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1207 W WINONA AVENUE WARSAW, IN46580
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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: Susan Reichert, Medical Surveyor III-Team Leader Kathy J. Wanner, Medical Surveyor III</p> <p>Facility number: 000881 Provider number: 15G367 AIM number: 100249180</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		
W0122	<p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections. The facility failed for 2 of 9 clients who had lived in the group home (clients #5 and #6) by failing to implement client #5's plan to prevent him</p>	W0122	<p>W122</p> <p>The Facility must ensure that specific client protections requirements are met.</p> <p>09/30/2011 Client #5's</p>	10/07/2011

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>from eating inappropriate food, and failed to ensure the safety of client #6 by ensuring he wore clothing to prevent falls after he was identified as a fall risk.</p> <p>Findings include:</p> <p>Please see W149. The facility neglected to implement written policy and procedures to protect 3 of 9 clients who lived in the group home (clients #5, #6 and #8) by failing to implement client #5's plan to prevent him from eating inappropriate food, failed to ensure the safety of client #6 by ensuring he wore clothing to prevent falls after he was identified as a fall risk, and failed to supervise client #8 as per his plan.</p> <p>9-3-2(a)</p>		<p>Self-Management Plan was amended to include eyesight supervision while Client #5 is in the kitchen. (see attachment A) On 09/30/2011 and 10/07/2011 Direct Support Professionals were trained on this updated plan. (see Attachments B and C)</p> <p>On 09/20/2011 a Plan of Protection was put in place for Client #6 to ensure that clothing is worn in a manner that prevents placing Client #6 at risk for falls. All West Winona Direct Support Professionals were trained on the Plan of Protection by 09/26/2011 and on 10/07/2011. (see attachments C and D)</p> <p>To ensure this deficiency does not occur again, the Residential Manager, Qualified Disability Professional (QDP) and Residential Coordinator will monitor the implementation of all individualized plans through weekly, monthly and quarterly observations.</p> <p>QDP, Residential Manager and Residential Coordinator Responsible</p>		

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W0137	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, the facility failed to assure 1 of 7 clients residing in the home (client #6) wore appropriate clothing to encourage safe mobility.</p> <p>Findings include:</p> <p>During observation at the group home on 9/19/11 from 4:50 PM until 6:30 PM client #6 used a merry walker to ambulate and wore socks that had 4 inches in excess extending from his toes and his pants were dragging on the floor. Staff #7 used a gait belt to assist client #6 to the table for dinner.</p> <p>Staff #7 was interviewed on 9/19/11 at 6:05 PM. He indicated client #6 used the merry walker to prevent falls and stated client #6 will sometimes "throw himself down." Staff #7 indicated client #6 was at risk for falls. Client #6's socks and pants were pointed out to staff #7 during the interview with staff #7 by the surveyor while client #6 ate his dinner, but staff #7 did not assist client #6 to adjust his clothing.</p>	W0137	<p>W137 The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. On 09/20/2011 a Plan of Protection was put in place for Client #6 to ensure that clothing is worn in a manner that prevents placing Client #6 at risk for falls. Staff #7 was trained on the Plan of Protection on 09/20/2011. All West Winona Direct Support Professionals were trained on the Plan of Protection by 09/26/2011. (see attachment D) To ensure this deficiency does not occur again, the Residential Manager, Qualified Disability Professional (QDP) and Residential Coordinator will monitor the implementation of all individualized plans through weekly, monthly and quarterly observations. QDP, Residential Manager and Residential Coordinator Responsible</p>	09/30/2011	

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	<p>A BDDS report dated 9/19/11 at 7:15 PM was reviewed on 9/20/11 at 12:45 PM. The report indicated after client #6 finished his dinner, "he would not allow staff to assist him with putting his helmet back on. [Client #6] communicated his desire to not wear the helmet with loud vocalizations and attempted physical aggression with staff...Staff utilized [client #6's] gait belt to assist him to the restroom...While walking in the hallway with [client #6], staff accidentally stepped on [client #6's] sock which caused him (client #6) to fall down. Staff tried to soften his fall by holding the gait belt, but he (client #6) received a 1/2 inch scratch above his left eyebrow and a 1/8 inch scratch on the left side of his forehead." An attached Plan of Protection (undated) regarding client #6's fall on 9/19/11 indicated "Staff should assist [client #6] in straightening his socks if they are bunched up or coming off his feet. There should not be any dangling fabric that could be stepped on by someone else and cause a fall," and "Staff should assist [client #6] in pulling up his pants so that his pant legs do not drag on the floor. If the pant legs are too long, staff should assist [client #6] in rolling them up so no one can step on them causing a fall."</p> <p>The Program Coordinator was interviewed on 9/20/11 at 11:00 AM.</p>				

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W0149	<p>When asked if client #6's fall was preventable, she stated, "Yes."</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility neglected to implement written policy and procedures to protect 3 of 9 clients who lived in the group home (clients #5, #6 and #8) by failing to implement client #5's plan to prevent him from eating inappropriate food, failed to ensure the safety of client #6 by ensuring he wore clothing to prevent falls after he was identified as a fall risk, and failed to supervise client #8 as per his plan.</p> <p>Findings include:</p> <p>1. During observation at the group home on 9/19/11 from 4:50 PM until 6:30 PM, client #5 sat on the floor of the kitchen at 4:55 PM. While staff #7 and #10 had their backs turned, client #5 opened the refrigerator door, took out a bottle of ketchup, tipped it up and took two gulps before staff were prompted by the</p>	W0149	<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>09/30/2011 Client #5's Self-Management Plan was amended to include eyesight supervision while Client #5 is in the kitchen. (see attachment A) On 09/30/2011 and 10/07/2011 Staff #7, Staff #10 and all West Winona Direct Support Professionals were trained on this updated plan. (see Attachments B and C) On 10/12/2011 Staff #10 received specific training regarding Client #5's Self-Management and support needs. (see attachment E) All West Winona Direct Support Professionals will receive</p>	10/23/2011

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	<p>surveyor regarding client #5's possession of the ketchup.</p> <p>Staff #10 was interviewed on 9/19/11 at 4:58 PM. When asked about a plan to address client #5's drinking of ketchup, she stated, "If he does that we put mitts on his hand so he can't open stuff."</p> <p>Client #5's record was reviewed on 9/19/11 at 5:30 PM. His Self Management Plan located in the group home dated November, 2010 did not include the use of mitts. His plan indicated "I enjoy eating very much and have been observed on many occasions to take food that does not belong to me or to take food from the refrigerator before it has been properly cooked. I have also attempted to drink ketchup or salad dressing directly from the bottle...Staff should observe me very closely any time someone is eating around me or when I am in the kitchen."</p> <p>The Program Coordinator was interviewed on 9/21/11 at 11:00 AM and indicated client #5 did not have the use of mitts in his plan to prevent him from eating ketchup and staff should supervise him closely while in the kitchen.</p> <p>2. During observation at the group home on 9/19/11 from 4:50 PM until 6:30 PM</p>		<p>training by 10/23/2011 regarding Client #5's Finger Control Mitts Plan dated 12/08/2010 (see attachment F) specifying that Finger Control Mitts will only be used with Client #5 in regards to physical aggression to his peers and staff and not as a means to prevent PICA or gain access to food items. (see attachment F)</p> <p>On 09/20/2011 a Plan of Protection was put in place for Client #6 to ensure that clothing is worn in a manner that prevents placing Client #6 at risk for falls. Staff #7 was trained on the Plan of Protection on 09/20/2011. All West Winona Direct Support Professionals were trained on the Plan of Protection by 09/26/2011. (see Attachments C and D)</p> <p>On 10/28/2010 Direct Support Professionals that failed to provide for Client #8's safety received formal disciplinary action (see attachment G) By 11/01/2010 all West Winona Direct Support Professionals Received additional training regarding Person Served Support Needs (see attachment H) and Leaving</p>		

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	<p>client #6 used a merry walker to ambulate and wore socks that had 4 inches in excess extending from his toes and his pants were dragging on the floor. Staff #7 used a gait belt to assist client #6 to the table for dinner.</p> <p>Staff #7 was interviewed on 9/19/11 at 6:05 PM. He indicated client #6 used the merry walker to prevent falls and stated client #6 will sometimes "throw himself down." Staff #7 indicated client #6 was at risk for falls. Client #6's socks and pants were pointed out to staff #7 during the interview with staff #7 by the surveyor while client #6 ate his dinner, but staff #7 did not assist client #6 to adjust his clothing.</p> <p>A BDDS report dated 9/19/11 at 7:15 PM was reviewed on 9/20/11 at 12:45 PM. The report indicated after client #6 finished his dinner, "he would not allow staff to assist him with putting his helmet back on. [Client #6] communicated his desire to not wear the helmet with loud vocalizations and attempted physical aggression with staff...Staff utilized [client #6's] gait belt to assist him to the restroom...While walking in the hallway with [client #6], staff accidentally stepped on [client #6's] sock which caused him (client #6) to fall down. Staff tried to soften his fall by holding the gait belt, but</p>		<p>Persons Served Unattended. (see attachment I) All Direct Support Professionals were trained regarding Leaving Persons Served Unattended by 11/2/2010. (see attachment J)</p> <p>To ensure this deficiency does not occur again, the Residential Manager, Qualified Disability Professional (QDP) and Residential Coordinator will monitor the implementation of all individualized plans through weekly, monthly and quarterly observations.</p> <p>QDP, Residential Manager and Residential Coordinator Responsible</p>		

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	<p>he (client #6) received a 1/2 inch scratch above his left eyebrow and a 1/8 inch scratch on the left side of his forehead." An attached Plan of Protection (undated) regarding client #6's fall on 9/19/11 indicated "Staff should assist [client #6] in straightening his socks if they are bunched up or coming off his feet. There should not be any dangling fabric that could be stepped on by someone else and cause a fall," and "Staff should assist [client #6] in pulling up his pants so that his pant legs do not drag on the floor. If the pant legs are too long, staff should assist [client #6] in rolling them up so no one can step on them causing a fall."</p> <p>The Program Coordinator was interviewed on 9/20/11 at 11:00 AM. When asked if client #6's fall was preventable, she stated, "Yes."</p> <p>3. The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/19/11 at 2:40 PM. A report dated 10/28/10 indicated client #8 was left alone at the group home while staff took the other clients living in the group home to day services. Upon arrival at the day services staff realized client #8 had been left behind and returned to the group home where client #8 was found with maintenance staff. Client #8 had been left alone about 2</p>				

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	<p>minutes per the report and staff were disciplined for the incident and retrained on staffing ratios, and client support needs. The report indicated all agency staff would be trained to complete a head count prior to leaving an area to ensure all clients were accounted for.</p> <p>The Program Coordinator was interviewed on 9/21/11 at 11:45 AM and indicated client #8 required 24 hour supervision and agency staff had been disciplined and retrained regarding client supervision needs.</p> <p>A review of the facility's "Incident/Abuse/Neglect Policy", dated 3/11 on 9/19/11 at 4:15 PM, indicated, the agency "is committed to ensuring the safety, dignity, and protections of persons served."</p> <p>9-3-2(a)</p>				

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W0191	<p>For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. Based upon record review and interview, the facility failed to ensure staff were trained to demonstrate competency to implement 1 of 7 clients living in the group home (client #5's) plan to address behavior of eating inappropriate food items.</p> <p>Findings include:</p> <p>During observation at the group home on 9/19/11 from 4:50 PM until 6:30 PM, client #5 sat on the floor of the kitchen at 4:55 PM. While staff #7 and #10 had their backs turned, client #5 opened the refrigerator door, took out a bottle of ketchup, tipped it up and took two gulps before staff were prompted by the surveyor regarding client #5's possession of the ketchup.</p> <p>Staff #10 was interviewed on 9/19/11 at 4:58 PM. When asked about a plan to address client #5's drinking of ketchup, she stated, "If he does that we put mitts on his hand so he can't open stuff."</p> <p>Client #5's record was reviewed on 9/19/11 at 5:30 PM. His Self Management Plan located in the group home dated November, 2010 did not</p>	W0191	<p>W191</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>09/30/2011 Client #5's Self-Management Plan was amended to include eyesight supervision while Client #5 is in the kitchen. (see attachment A) On 09/30/2011 Staff #7, Staff #10 and all West Winona Direct Support Professionals were trained on this updated plan. (see Attachment B) On 10/12/2011 Staff #10 received specific training regarding Client #5's Self-Management and support needs. (see attachment E) All West Winona Direct Support Professionals will receive training by 10/23/2011 regarding Client #5's Finger Control Mitts Plan dated 12/08/2010 (see attachment F) specifying that Finger Control Mitts will only be used with Client #5 in regards to physical aggression to his peers and staff and not as a</p>	10/23/2011			

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	<p>include the use of mitts. His plan indicated "I enjoy eating very much and have been observed on many occasions to take food that does not belong to me or to take food from the refrigerator before it has been properly cooked. I have also attempted to drink ketchup or salad dressing directly from the bottle...Staff should observe me very closely any time someone is eating around me or when I am in the kitchen."</p> <p>The Program Coordinator was interviewed on 9/21/11 at 11:00 AM and indicated client #5 did not have the use of mitts in his plan to prevent him from eating ketchup and staff should supervise him closely while in the kitchen.</p> <p>The Qualified Mental Retardation Professional Professional Designee (QMRPD) was interviewed on 9/19/11 at 11:37 AM. When asked about staff implementing client #5's plan to address eating inappropriate items, she stated "They're supposed to watch him in the kitchen," and "I'll have to address that." She indicated staff #10 had not yet completed her training for the group home and would not be fully trained to implement plans until 3 weeks into her employment.</p> <p>9-3-3(a)</p>		<p>means to prevent PICA or gain access to food items. (see attachment F)</p> <p>By 10/23/2011 Residential Managers will receive training specifying that staff will not be permitted to work unsupervised as Direct Support Staff until they have been trained on the specific Support Plans and needs of the clients in the home.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, Qualified Disability Professional (QDP) and Residential Coordinator will monitor the implementation of all individualized plans through weekly, monthly and quarterly observations. The Residential Coordinator will review new-hire training documents to confirm that new staff has been trained on support needs.</p> <p>QDP, Residential Manager and Residential Coordinator Responsible</p>		

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W0249	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed to implement 1 of 2 clients discharged from the group home during the past year (client #8) plan by failing to supervise him as indicated in his Individual Support Plan (ISP), and failed to implement 1 additional client (client #5's) Self Management Plan (SMP) regarding pica behavior.</p> <p>Findings include:</p> <p>1. The facility's reports to the Bureau of Developmental Disabilities Services were reviewed on 9/19/11 at 2:40 PM. A report dated 10/28/10 indicated client #8 was left alone at the group home while staff took the other clients living in the group home to day services. Upon arrival at the day services staff realized client #8 had been left behind and</p>	W0249	<p>W249</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program</p> <p>On 10/28/2010 Direct Support Professionals that failed to provide for Client #8's safety received formal disciplinary action (see attachment G) By 11/01/2010 all West Winona Direct Support Professionals Received additional training regarding Person Served</p>	10/23/2011

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	<p>returned to the group home where client #8 was found with maintenance staff. Client #8 had been left alone about 2 minutes per the report and staff were disciplined for the incident and retrained on staffing ratios, and client support needs. The report indicated all agency staff would be trained to complete a head count prior to leaving an area to ensure all clients were accounted for.</p> <p>Client #8's record was reviewed on 9/30/11 at 12:30 PM. His ISP dated 4/1/11 indicated he required 24 hour supervision.</p> <p>The Program Coordinator was interviewed on 9/21/11 at 11:45 AM and indicated client #8 required 24 hour supervision and agency staff had been disciplined and retrained regarding client supervision needs.</p> <p>2. During observation at the group home on 9/19/11 from 4:50 PM until 6:30 PM, client #5 sat on the floor of the kitchen at 4:55 PM. While staff #7 and #10 had their backs turned, client #5 opened the refrigerator door, took out a bottle of ketchup, tipped it up and took two gulps before staff were prompted by the surveyor regarding client #5's possession of the ketchup.</p>		<p>Support Needs (see attachment H) and Leaving Persons Served Unattended. (see attachment I) All Direct Support Professionals were trained regarding Leaving Persons Served Unattended by 11/2/2010. (see attachment J)</p> <p>On 09/30/2011 Client #5's Self-Management Plan was amended to include eyesight supervision while Client #5 is in the kitchen. (see attachment A) On 09/30/2011 Staff #7, Staff #10 and all West Winona Direct Support Professionals were trained on this updated plan. (see Attachment B) On 10/12/2011 Staff #10 received specific training regarding Client #5's Self-Management and support needs. (see attachment E) All West Winona Direct Support Professionals will receive training by 10/23/2011 regarding Client #5's Finger Control Mitts Plan dated 12/08/2010 (see attachment F) specifying that Finger Control Mitts will only be used with Client #5 in regards to physical aggression to his peers and staff and not as a means to prevent PICA or</p>		

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	<p>Staff #10 was interviewed on 9/19/11 at 4:58 PM. When asked about a plan to address client #5's drinking of ketchup, she stated, "If he does that we put mitts on his hand so he can't open stuff."</p> <p>Client #5's record was reviewed on 9/19/11 at 5:30 PM. His Self Management Plan located in the group home dated November, 2010 did not include the use of mitts. His plan indicated "I enjoy eating very much and have been observed on many occasions to take food that does not belong to me or to take food from the refrigerator before it has been properly cooked. I have also attempted to drink ketchup or salad dressing directly from the bottle...Staff should observe me very closely any time someone is eating around me or when I am in the kitchen."</p> <p>The Program Coordinator was interviewed on 9/21/11 at 11:00 AM and indicated client #5 did not have the use of mitts in his plan to prevent him from eating ketchup and staff should supervise him closely while in the kitchen.</p> <p>9-3-4(a)</p>		<p>gain access to food items. (see attachment F)</p> <p>To ensure this deficiency does not occur again, the Residential Manager, Qualified Disability Professional (QDP) and Residential Coordinator will monitor the implementation of all individualized plans through weekly, monthly and quarterly observations.</p> <p>QDP, Residential Manager and Residential Coordinator Responsible</p>		

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W0318	<p>The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review, and interview, the Condition of Participation, Health Care Services is not met as the facility failed failed to provide adequate health care monitoring and nursing services for 1 of 4 sampled clients (client #1), 2 of 2 discharged clients (clients #7 and #8) and 1 additional client (client #5) by failing to establish client specific protocols in accordance with their identified medical needs (clients #1, #5, #7 and #8) and failed to document nursing assessments to evaluate the deteriorating medical condition of (client #8).</p> <p>Findings include:</p> <p>1. Please refer to W331. The facility failed failed to provide adequate health care monitoring and nursing services for 1 of 4 sampled clients (client #1), 2 of 2 discharged clients (clients #7 and #8) and 1 additional client (client #5) by failing to establish client specific protocols in accordance with their identified medical needs (clients #1, #5, #7 and #8) and failed to document nursing assessments to evaluate the deteriorating medical</p>	W0318	<p>W318</p> <p>The facility must ensure that specific health care services requirements are met.</p> <p>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 K) Clients #1 and 5 were re-evaluated to determine the need for client specific protocols on 10-21-11 (see attachment K). Client specific protocols will be developed and implemented for each person with identified risk by October 30, 2011.</p> <p>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.</p> <p>Coordinator, Manager and Nurse Responsible.</p>	10/30/2011

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W0331	<p>condition of (client #8).</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 observation, record review and interview, nursing services failed to provide adequate health care monitoring and nursing services for 1 of 4 sampled clients (client #1), 2 of 2 discharged clients (clients #7 and #8) and 1 additional client (client #5) by failing to establish client specific protocols in accordance with their identified medical needs (clients #1, #5, #7 and #8) and failed to document nursing assessments to evaluate the deteriorating medical condition of (client #8).</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/19/11 at 2:40 PM and indicated the following:</p>	W0331	<p>W331</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Nursing services will be provided in accordance with client needs as specified in each client's program plans, risk plans and health care plans.</p> <p>Specific and sufficient health care services will be provided through the implementation of client specific protocols for identified areas of risk.</p> <p>Physical Assessment Tool was revised to include parameters for BP, pulse, weight and temperature. (See attachment K). Nurses and staff were retrained on the new tool and guidelines of when to notify the nurse on 10-21-11. (see</p>	10/30/2011

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	<p>1. -a report dated 10/1/10 indicated client #5 had been found to have pneumonia after a chest X-ray to screen for tuberculosis. The report indicated client #5 was treated with antibiotics and his doctor followed up with his care. The report indicated "staff will continue to monitor [client #5's] health and report any changes to the nurse.</p> <p>Client #5's record was reviewed on 9/22/11 at 1:28 P.M.. Client #5's record indicated he had a history of pneumonia, recurrent upper respiratory infections (URI) and bronchitis. A swallow study dated 1/12/11 indicated "food gets trapped in his esophagus and he aspirates large amounts into his lungs." Staff were tracking for signs and symptoms of aspiration and monitoring his episodes of regurgitation. The Interdisciplinary Team (IDT) was meeting quarterly to review his status. Client #5's record did not include client specific protocols to include the signs and symptoms of pneumonia, URIs, and Bronchitis and to indicate when staff should notify the LPN.</p> <p>2. -a report dated 8/16/11 indicated client #8 had been admitted to a nursing home after being released from a hospital on 8/9/11. A follow up report dated 8/22/11 indicated client #8 was "having problems with his potassium dropping and is</p>		<p>attachment K).</p> <p>Nurses and QMRP's were trained on identifying areas of risk on 10-21-11 (see attachment K). Client specific protocols will be developed and implemented for each person with identified risk by October 30 th , 2011</p> <p>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.</p> <p>Coordinator, Nurse, QMRP and Manager Responsible.</p>				

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	<p>suspected to have an illius(sic)(bowel not working)...is eating pureed foods and drinking honey thick liquids...[client #8's] physical therapist states that [client #8] has made very little progress in moving his limbs, sitting up and no progress in standing at all...[Client #8's] doctors have not given us a prognosis or actual diagnosis...but have stated that he does not believe that we would be able to provide adequate supports for [client #8] in his group home setting. At this time we do not anticipate that [client #8] will be able to return to his home."</p> <p>Client #8's records were reviewed on 9/20/11 at 11:05 AM. A discharge summary dated 7/17/11 indicated client #8 was admitted to hospital #1 with diagnoses of acute respiratory failure, extensive bilateral pulmonary infiltrates with differential diagnosis of aspiration, pneumonia, decompensated congestive heart failure, or both, elevated troponin, suggestive of MI (myocardial infarction-heart attack), fever, hypotension, hypernatremia. The summary indicated client #8 was admitted to hospital #2 on July 14, 2011. "At that time, the patient had presented with nausea and vomiting, apparently was found to have a lithium toxicity with a lithium level of 3.0. Over the next few days after admission, lithium level</p>				

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	improved, but in the previous 24 hours before transferring to [current hospital name] respiratory situation deteriorated....Upon admission, [Dr. name] felt his risk factors for health care-associated pneumonia were increased due to the fact he lives in a group home, so therefore it required broad-spectrum antibiotics...." Admission and discharge information from the hospital admission on July 14, 2011 was not in client #8's record. A Medical Summary Progress Report dated 7/11/11 indicated he had seen his primary care physician for "coughing, digging in groin area and follow up on Ditropan (incontinence medication) also loose stools." The physician's order sheet included increased fluids. Physician's orders dated 7/25/11 indicated "check BP (blood pressure) monthly-notify MD (medical doctor) if over 140/90." A Physical Assessment Tool (PAT) dated 4/11 completed by direct support staff indicated client #8 had a blood pressure of 136/93. A PAT dated 5/28/11 indicated blood pressure of 137/95. A nursing note dated 4/30/11 indicated a PAT was completed and client #8 had a blood pressure of 136/93. Areas of concern noted are decreased appetite and weight loss. Staff will follow up with PCP (primary care physician). A nursing note for 6/22/11 indicated a PAT was completed for client #8 indicating blood				

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	pressure of 148/84 . "No areas of concern noted. " Nursing notes for the months of April and May did not document client #8's MD was notified of his elevated blood pressure. A nutritional assessment dated 7/4/11 indicated "continue current diet back to regular in light of significant weight loss...Continue to encourage consumption of 64 ounces fluid daily..." Client #8's Intake and Output (I and O) records for June and July, 2011 indicated staff were to notify the nurse if food intake is less than 25% 2 meals in a row. The I and O records were not totaled to indicate client #8's fluid intake. There was no documentation client #8's nurse had been notified when client #8 failed to eat less than 25% of his meals for 2 meals in a row. Client #8's progress notes from 6/22/11 to 7/11/11 indicated he failed to eat breakfast or drink juice on 6/22/11, ate 60% of his meal on 6/26/11 before leaving to go with his brother in the afternoon, failed to eat more than 25% of his lunch and failed to eat his evening meal until after his shower at which point he threw away 25% of his meal on 6/27/11, ate 25% of his breakfast on 6/28/11, ate cereal, but refused toast and eggs, milk and juice and lunch, drink at snack and refused milk at dinner on 6/29/11, ate half his breakfast, ate 50% of his lunch, refused his dinner, though "ate a little more" after his shower on 6/30/11,			

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	ate half his oatmeal, refused snack on 7/1/11, "ate very little" breakfast, "little lunch," and half of his supper on 7/2/11, ate half his breakfast, no lunch and "a couple of bites" at dinner on 7/3/11, ate 25% of breakfast, refused snack, "had a hard time deciding to eat lunch," ate "some" of his dinner and refused snack on 7/4/11, "wouldn't eat eat" breakfast, took 4 hours to eat 80% of lunch, and refused dinner on 7/5/11, ate "only a bite or two" of his breakfast and "was unsteady on his feet" and refused morning snack, ate 25% of lunch, "stared at his plate" during dinner, then "ate a little," then refused evening snack, on 7/6/11, on 7/7/11 he ate all his oatmeal and one bite of toast, refused morning snack, slept through morning craft and lunch preparations, stood "staring into space" and "ate a few bites" of dinner, on 7/8/11 he refused morning snack, and "demonstrated great difficulty with eating lunch and snack and ate 25% of his dinner, on 7/9/11 he refused breakfast, and dinner and "ate a couple of bites of lunch," on 7/10/11 he refused lunch and dinner, on 7/11/11 he refused breakfast, "awake off and on while watching the news, refused morning snack", and "slept..during craft time and lunch prep" and refused dinner, though ate 50% later in the evening, on 7/12/11 he refused all meals and on 7/13/11 "left to go to				

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	<p>doctor's appointment because [client #8] was vomiting, not drinking or eating much in last 24 hours." On 7/11/11 there was a nursing note that indicated client #8 had been taken to his PCP "for follow up on weight loss, loose stools, cough and scratching at the groin." There was a nursing note dated 7/13/11 client #8 was taken to the hospital for continued issues with nausea, vomiting and weight loss. Labs were taken and client #8 was instructed to return to the hospital for inpatient treatment for high lithium levels and dehydration. A Medical Summary Progress Report dated 7/13/11 indicated he was seen by a doctor for "Not eating in days, not drinking fluids, throwing up, and having diarrhea, not very responsive to anyone wanting to sleep (sic)." The physician's order sheet indicated a lithium level. There was no documentation to indicate client #8's prescribing psychiatrist for lithium had been notified of client #8's reduced fluid and food intake and no evidence of nursing assessments of client #8's condition from 6/22/11 until 7/11/11 available to review. There were no protocols in client #8's record to indicate monitoring of side effects of lithium or of signs and symptoms of lithium toxicity, high blood pressure and instructions as to when to notify the nurse of client #8's symptoms.</p>				

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	<p>Webpage http://nlm.nih.gov/medlineplus/ency/article/002667.htm of the US National Library of Medicine NIH (National Institutes of Health) was reviewed on 9/30/11 at 8:54 AM and indicated the following: "- Acute toxicity occurs when you intentionally or accidentally swallow too much of a lithium prescription. -Chronic toxicity occurs when you slowly take a little too much of a lithium prescription every day for a while. This is actually quite easy to do, as dehydration, other medications, and other conditions can easily interfere with lithium in your body and cause it to build up....." Acute toxicity included symptoms of diarrhea, weakness, nausea, stomach pains, vomiting and weakness. Additional symptoms of acute toxicity included seizures, hand tremors, incoordination slurred speech.</p> <p>Client #8's Psychiatric Medication Review/Addendums dated January 13, 2011, April 7, 2011, May, 6, 2011 and June 3, 2011 indicated the side effects of Lithium Carbonate ER included: increased thirst and urination, mild nausea, acne.</p> <p>The LPN (licensed practical nurse) was interviewed on 9/22/11 at 2:30 PM and indicated staff were to notify her when</p>				

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	<p>client #8 missed more than 25% of meals 2 meals in a row, but she did not review the I and O records, and reviewed the PAT's on a monthly basis. When asked about nursing assessments for client #8 from 6/22/11 until 7/13/11, she indicated she had assessed him, but there was no record of the assessment, had she had consulted with doctors, and stated, "I never noted any signs and symptoms of dehydration." She further indicated there was no protocol in place to give instructions to staff as to when to call the nurse or seek medical evaluation for client #8's symptoms.</p> <p>2. -a report dated 1/27/11 indicated client #9 had been admitted to the hospital's intensive care unit (ICU) on 1/27/11 with a diagnosis of aspiration and low hemoglobin. -a report dated 2/14/11 indicated client #9 had died in the hospital while a patient in the hospital. According to hospital staff, a nurse was suctioning client #9's airway and his heart stopped beating.</p> <p>The agency's death investigation summary was reviewed on 9/20/11 at 12:55 PM. The death certificate dated 2/14/11 indicated client #9 had died of aspiration. A swallow study dated 7/27/10 indicated client #9 had a history of aspiration and dysphagia. "Bedside swallow evaluation</p>				

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	<p>was done and NPO is recommended (nothing by mouth)...Pt (patient) is unable to perform dysphagia treatment at this time." There was no record of a protocol to address client #9's risk for aspiration or instructions to staff as to when to call the nurse or seek medical evaluation for client #9's potential for aspiration.</p> <p>3. Client #1's record was reviewed on 9/22/11 at 1:50 P.M.. Client #1's record indicated he had a history of pneumonia, and aspiration diagnosed with dysphagia/choking and was classified as a "high risk," with a dysphagia /choking plan 7/27/11. There were no client specific protocols available for review to indicate the signs and symptoms staff should monitor for regarding pneumonia, aspiration, dysphagia/choking, and to indicate when staff should notify the LPN.</p> <p>The LPN was interviewed on 9/22/11 at 2:30 PM and indicated there was not an individualized protocol in place to address client #9's potential for aspiration. She indicated staff were trained on protocols for pneumonia for all clients but there were no individualized protocols developed for individual client risks for pneumonia, aspiration or to indicate when staff should notify the nurse.</p> <p>9-3-6(a)</p>						

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W0340	<p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff implemented medication training to administer medications for 1 of 2 clients (#7) who were observed to receive their medications.</p> <p>Findings include:</p> <p>During medication administration at the group home on 9/19/11 at 5:15 PM, staff #7 used a paper cup and pair of pliers to crush client #7's medication of Prometazine 25 mg. He then placed the pliers in his pocket.</p> <p>Staff #7 was interviewed on 9/19/11 at 5:15 PM. When asked about crushing client #7's medications with a pair of pliers, he stated, "State wants us to do it like that."</p> <p>Living in the Community Medication</p>	W0340	<p>W340</p> <p>Nursing services must include implementing with other member s of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to, training clients and staff as needed in appropriate health and hygiene methods.</p> <p>West Winona Direct Support Professionals reviewed using the appropriate device for crushing medications on 10/07/2011. (see Attachment C.) All West Winona Direct Support Professionals will receive additional training on using only approved devices for crushing medications and ensuring the device is cleaned after each use by 10/23/2011. All group home Direct Support</p>	10/30/2011

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1207 W WINONA AVENUE WARSAW, IN46580		
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W0346	<p>Administration Manual dated 2004 was reviewed on 9/28/11 at 6:11 PM. The Medication Administration Checklist for Crushing Tablets indicated at step 6 "obtain a mortar and pestle or a leverage-type crusher and an alcohol swab." Step 12 indicated "Place tablets to be crushed in a paper cup with a paper cup on top so the crushing apparatus does not touch the medications." Step 13 indicated " Press down on the crusher or twist the pestle to crush the medication."</p> <p>9-3-6 (a)</p> <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 9 of 9 clients who lived in the home (Clients #1, #2, #3, #4, #5, #6, #7, #8 and #9) the facility failed to have a Registered Nurse (RN) on staff or to have a formal arrangement with an RN to</p>	W0346	<p>Professionals will be trained on using only approved devices for crushing medication and ensuring the device is cleaned after each use by 10/30/2011.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, Qualified Disability Professional (QDP), Nurse and Residential Coordinator will monitor the use of approved devices for crushing medications through weekly, monthly and quarterly observations.</p> <p>QDP, Residential Manager, Nurse and Residential Coordinator Responsible</p> <p>W346 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</p>	10/30/2011	

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	<p>be available for verbal or onsite consultations to the LPNs.</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 for clients #1, #2, #3, #4, #5., #6, #7. #8 and #9. There was no indication the facility had an RN on staff.</p> <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>Department of Cardinal Services. She is available for verbal or onsite consultation. (see attachment L) To ensure ongoing compliance, Director will maintain formal agreement with the WIC RN. Director and Nurse Responsible.</p>		

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W0388	<p>Labeling for drugs and biologicals must be based on currently accepted professional principles and practices.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 2 clients (client #2), who were observed to receive medication, to ensure the label matched the medication administration record (MAR).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/19/11 4:50 PM until 6:30 PM. Client #5's medication of Promethazine 25 mg was administered by staff #7 at 5:25 PM. The label on the medication had a paper taped to it that indicated 7 AM, 12 noon, 5 PM and 10 PM.</p> <p>Client #5's September, 2011 MAR was reviewed on 9/19/11 at 5:30 PM and indicated Promethazine 25 mg, 1 tab three times a day as needed.</p> <p>Staff #7 was interviewed on 9/19/11 at 7:30 PM and when asked about the label on client #5's medication, he stated, "This just happened today," and indicated he had attached the note to client #5's medication label to give instructions to staff as the nurse had given the group home instructions to provide the</p>	W0388	<p>W388</p> <p>Labeling for drugs and biological must be based on currently accepted professional principles and practices.</p> <p>West Winona Direct Support Professionals reviewed correct medication labeling procedures on 10/07/2011. (see attachment C) All West Winona Direct Support Professionals will receive additional training regarding the correct procedure for labeling medications by 10/23/2011. All group home Direct Support Professionals will be trained on the correct procedure for labeling medications by 10/30/2011.</p> <p>To ensure that this deficiency does not occur in the future, the Residential Manager, Qualified Disability Professional (QDP), Nurse and Residential Coordinator will monitor for correct medication labeling during weekly, monthly and quarterly observations.</p>	10/30/2011

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W0460	<p>medication more consistently than in the past to address client #5's vomiting behavior. He indicated there was a note in the communication log regarding the instruction.</p> <p>A 9/19/11 Communication Log was reviewed on 5:32 PM and indicated "Per [LPN] we need to get in practice of using [client #5] Promethazine more routinely when he is vomiting. She suggested these times 7a (AM), 12 n (noon), 5 P (PM) and 10 P."</p> <p>The house manager was interviewed on 9/19/11 at 5:35 PM and indicated the medication label should match the MAR.</p> <p>9-3-6(a)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based upon observation, record review, and interview for 1 of 8 clients living in the group home, (client #6), the facility failed to ensure his food was prepared to the consistency as specified in his diet plan.</p> <p>Findings include:</p>	W0460	<p>QDP, Residential Manager, Nurse and Residential Coordinator Responsible</p> <p>W460 Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. On 09/30/2011(see Attachment M) West Winona Direct Support Professionals received training regarding Client #6's meal preparation recommendations, specifically that "Any vegetable (potatoes included) should be</p>	10/07/2011	

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	<p>The facility's reportable incidents to the Bureau of Developmental Disability Services (BDDS) were reviewed on 9/19/11 at 2:40 PM and included the following report for client #6:</p> <p>-an incident dated 12/10/10 indicated client #6 required the Heimlich maneuver to dislodge vegetables he had eaten. Attached to the report was a Plan of Protection dated 12/10/10 for client #6. The plan indicated "The IDT (interdisciplinary team) believes that [client #6] may not be chewing thoroughly, there has difficulty when swallowing." The plan indicated client #6 would be evaluated by the dietitian and the speech therapist. A Dysphagia Assessment dated 1/3/11 indicated a mechanical soft diet was appropriate for client #6 and "It is recommended, however, that cooked vegetables should always be well-covered with a sauce, gravy or salad dressing to facilitate the formation of a bolus and prevent isolated particles from creating a risk of aspiration." A Plan of Protection dated January 4, 2011 indicated client #6 was to receive a mechanical soft diet. "Staff has been trained on adding sauce, gravy or salad dressing to cooked vegetables...."</p> <p>During the observation period on 9/19/11</p>		<p>well covered in a sauce, gravy or salad dressing to aide in swallowing." On 10/07/2011 West Winona staff reviewed Client #6's dietary guidelines once again during the Department Meeting. (see Attachment C and M) To ensure that this deficiency does not occur in the future, meal preparation and dietary guidelines will be monitored through weekly, monthly and quarterly observation by the Residential Manager, Qualified Disability Professional (QDP) and Residential Coordinator. Residential Manager, Qualified Disability Professional (QDP) and Residential Coordinator responsible.</p>	

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	<p>from 4:50 PM until 6:30 PM, client #6 ate his dinner at 6:05 PM. Client #6's potatoes were served without sauce or gravy added to them.</p> <p>The Qualified Mental Retardation Professional Designee (QMRPD) was interviewed on 9/21/11 at 12:15 PM. She indicated client #6's potatoes should have been served with gravy added to them.</p> <p>9-3-8 (a)</p>				