STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G536	A. BUILDING 00 B. WING	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL SERVICES INC OF INDIANA	1008 SHORT DRIVE KNOX, IN 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the Post Certification Revisit (PCR) to the predetermined full recertification and state licensure survey completed on 5/22/24. This visit was in conjuntion with the investigation of complaint #IN00438258. Dates of survey: October 1, 2, 3, 4 and 9, 2024. Facility Number: 001050 Provider Number: 15G536 AIMS Number: 100245380 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 10/16/24.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY Based on observation, record review, and interview for 1 of 3 sample clients (B), plus 1 additional client (E), the facility failed to ensure the fire exit in clients B and E's bedroom was accessible. Findings include: An observation was conducted in the group home on 10/2/24 from 5:40 am to 7:30 am. Clients B and E were present in the home throughout the observation period. On 10/2/24 at 6:50 am, the exterior door in clients B and E's bedroom was blocked by a laundry basket.	W 0104	On 10/22/24 Client B & Client E were assisted with clearing the path to the emergency exit doors in their rooms. The clients were educated on the importance of keeping a clear path in case of emergencies. Furthermore, the staff and house supervisors were trained on the importance of all emergency exits to be clear of clutter to be able to evacuate if necessary. (attachment A). To ensure this deficiency does not occur again, the QDP will increase	10/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Boards	QDP	10/24/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Laundry was piled against the door. The floor in the bedroom was partially covered with clothing, paper towels, empty soda bottles, and other garbage. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 10/9/24 at 1:34 pm and stated, "Staff should be prompting [client B] to get that moved from in front of the door. If he does not, they should assist him with getting that out of the way, so it is not a hazard." Assistant Residential Director (ARD) #1 was interviewed by phone on 10/4/24 at 10:20 am and stated, "Staff go in at least once a week to assist with cleaning the room. We were there last week for a house meeting, and it was a topic of conversation. Staff move things, and [client B] moves them back where he wants them. The staff should teach him." This deficiency was cited on 5/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)		oversight on the cleanliness of the client bedrooms to ensure that the emergency exits are clear from clutter. QDP Responsible.	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 3 sample clients (A), the facility failed to implement its written policy and procedure to provide client A with a gait belt as indicated in her risk plan resulting in a fall with injury. Findings include: The facility's Bureau of Disabilities Services reports and related investigations were reviewed	W 0149	On 10/23/24 the DSP's and House Supervisor were retrained on Client A's fall risk plan (attachment A). Furthermore, they were retrained that Client A will be assisted to put on her gait belt during wake hours. (attachment B). Also, Client A's PCISP (attachment C) was updated to include her community staff goal to include	10/25/2024

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	on 10/3/24 at 9:40 am. A BDS report dated 7/7/24 indicated the following: "On 7/6/24 it was reported that while on an outing at a park, [client A] got dizzy and hot. She fell on the grass and landed on her buttocks. Consumer reported pain, staff called 911 EMS (emergency medical services). Consumer refused service from EMS. Staff took her home and contacted her guardian who asked staff to take consumer to the ER (emergency room). At ER, x-rays showed a non-displaced fracture of the tail bone. Consumer was discharged at 8:00 pm with Ibuprofen (pain reliever) and rest orders." An investigation dated 7/12/24 indicated the following: "I found no discrepancies. [Staff] was approximately 15 feet away from [client A] while taking pictures of the other client, that he requested for her to do. [Client A] and [peer] were always within eyesight. [Client A] does have a fall plan that states that staff is to utilize her gait belt when walking long distances. When I questioned why she did not have a gait belt on, [staff] told me that she has not had one since she moved in. I then contacted [House Manager (HM) #1], and she verified that [client A] does not have a gait belt. If a gait belt is recommended in her risk plan, her doctor should be contacted to get an order for one and then get one for her to help ensure her safety." Client A's record was reviewed on 10/3/24 at 9:58 am and indicated an admission date of 1/3/24. Client A's fall risk plan dated 12/20/23 indicated the following: "Interventions: Staff will utilize [client A's] gait belt when walking long distances or walking with a continued shuffling gait."		gait belt use. To ensure this deficiency does not occur again, the QDP will increase oversight at the home to ensure Client A's gait belt is being used until competency is demonstrated. QDP Responsible	

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	HM #1 was interviewed on 10/2/24 at 7:19 am and stated, "[Client A] has only had the gait belt for a couple of weeks. It is new. She is still not very happy about it. She is trying to get used to it." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 10/9/24 at 1:34 pm and stated, "[Client A] should have had a gait belt in July if it was in her plan. She does have one now." Registered Nurse (RN) #1 was interviewed by phone on 10/9/24 at 12:44 pm and stated, "[Client A] did not have a gait belt in July. She does have a new one. She should have had the gait belt available. I doubt she did have one. She does not want to wear it." Assistant Residential Director (ARD) #1 was interviewed by phone on 10/4/24 at 10:20 am and stated, "The gait belt was in [client A's] plan at the time, but staff had not been utilizing it. We have made sure everyone is aware. She is to be wearing it at all times. There was one in her risk plan. When we investigated, we were made aware staff had not been utilizing the gait belt as they should have been." 9-3-2(a)			
W 0371 Bldg. 00	483.460(k)(4) DRUG ADMINISTRATION Based on observation, record review, and interview for 1 of 3 sample clients (C), the facility to ensure client C had a goal to learn to administer her own medications. Findings include:	W 0371	On 10/22/24 Client C's self-administration plan (attachment B) was updated to include guidelines on identifying her medication to staff during med pass and outlined who was	10/25/2024

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	An observation was conducted in the group home on 10/2/24 from 5:40 am to 7:30 am. Client C was present throughout the observation period. On 10/2/24 at 6:19 am, House Manager (HM) #1 prepared client C's medications. Client C's morning medications were stored in a pill box marked with each day of the week and 4 times for a each day with a total of 28 separate boxes. HM #1 stated, "The medications are prepared at the beginning of the month, and we make sure they are all in there when we pass the medications." HM #1 indicated 6 of client C's medications were in the pill box and 3 were not. HM #1 compared the pills in the pill box to medication cards and the electronic Medication Administration Record (MAR). At 6:33 am, the surveyor compared the prepared medications to the MAR and medication cards. The MAR dated October 2024 indicated the following prescribed medication, "Myrbetriq 50 mg (milligrams), once daily, for incontinence." There was not a corresponding medication card. There was a yellow, oblong pill in the pill box without a corresponding medication card. The surveyor asked HM #1 to identify the unknown pill. HM #1 stated, "It's all prepared ahead of time. I do not have the medication card anymore. I do not know what that one is." At 6:37 am, HM #1 called client C to the medication room. Client C was not prompted to wash her hands or to bring a drink with her. HM #1 asked client C what her Myrbetriq was for. Client C indicated she did not know. The surveyor looked up the purpose of the medication, and client C stated, "The yellow one is for incontinence." HM #1 indicated the unidentified yellow pill in client C's pill box was her prescribed Myrbetriq. Client C poured the		responsible for reordering medication and when to reorder. Furthermore, Client C's PCISP (attachment C) was updated to include a health and wellness goal of self-administering medication. Staff and house supervisor were retrained on the updated plan and PCISP on 10/23/24 (attachment A). Also, on 10/23/24 staff and house supervisors were retrained (attachment A) on universal precautions (attachment D), specifically on the requirement of washing and/or sanitizing hands after before & after eating, drinking, smoking, applying cosmetics or preparing food and passing medications. The training also included the sanitary concerns of sharing drinks. To ensure this deficiency does not occur again, the Residential Nurse will increase oversight during medication pass to ensure all plans are being followed correctly and that staff and clients are washing their hands at appropriate times. Residential nurse responsible	

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	pills from her pill box into her hand and put them in her mouth. Client C picked up a mug of coffee from the counter and drank it with her pills. HM #1 stated, "That's mine, missy." Client C stated, "It's good." Client C offered the mug to HM #1, and HM #1 stated, "You've drank it now, you might as well finish it. I'm not going to drink it." Client C's record was reviewed on 10/3/24 at 11:00 am. Client C's ISP dated 6/2/24 did not include a goal for client C to prepare and administer her own medications. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 10/9/24 at 1:34 pm and stated, "[Client C] has a goal to monitor her medication supply and will notify staff when she has 7 pills left." QIDP #1 stated, "She does not have a goal to learn what the medications are. She should be helping to prepare the medication and to compare what she is taking to what she is prescribed." Client C's ISP dated 6/2/24 did not include a goal to notify staff when her medication supply was below 7 days. 9-3-6(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL Based on observation and interview for 3 of 3 sample clients (A, B, and C), plus 5 additional clients D, E, F, G, and H, the facility failed to implement universal precautions for infection control to ensure client C washed her hands prior to administering her own medications, to ensure client C did not drink staff's coffee when taking	W 0455	On 10/23/24 the DSPs and Residential Supervisor were retrained (attachment A) on universal precautions (attachment D), specifically on the requirement of washing and/or sanitizing hands after before & after eating,	10/25/2024

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	her medications, and to ensure client G did not eat from the serving dish shared by clients A, B, C, D, E, F, and H. Findings include: An observation was conducted in the group home on 10/2/24 from 5:40 am to 7:30 am. Clients A, B, C, D, E, F, G, and H were present in the home throughout the observation period. 1. On 10/2/24 at 6:33 am, House Manager (HM) #1 prompted client C to the medication room and prompted her to take her medication. Client C poured her medications from her pill box into her hand and put them in her mouth. Client C did not wash or sanitize her hands before taking her medication and was not prompted to do so. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 10/9/24 at 1:34 pm and stated, "Staff should prompt clients to wash their hands before coming to the medication room." Registered Nurse (RN) #1 was interviewed by phone on 10/9/24 at 12:44 pm and stated, "When clients come to the medication room, they should wash their hands. Staff should prompt them." Assistant Residential Director (ARD) #1 was interviewed by phone on 10/4/24 at 10:20 am and stated, "Clients should wash their hands before medication passes. Staff should prompt them if they do not do it on their own." 2. On 10/2/24 at 6:33 am, HM #1 prompted client C to the medication room and prompted her to take her medication. Client C took her medication and picked up a mug from the counter and drank from		drinking, smoking, applying cosmetics or preparing food and passing medications. The training also included the sanitary concerns of sharing drinks. The training also included the risk of cross contamination from eating out of a shared dish. The clients were also educated on the importance of washing their hands, not sharing drinks, and plating food separately out of a shared dish. To ensure the deficiency does not occur again, the Residential Nurse and Residential QDP will increase oversight in the home to ensure that universal precautions are being followed in the home. Residential Nurse and Residential QDP responsible.	

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	it. HM #1 stated, "That's mine, missy." Client C stated, "It's good." Client C offered the mug to HM #1, and HM #1 stated, "You've drank it now, you might as well finish it. I'm not going to drink it." Staff did not prompt client C to bring her own drink to the medication room to drink with her medications. QIDP #1 was interviewed by phone on 10/2/24 at 1:34 pm and stated, "Staff should prompt [client C] to get her own beverage instead of drinking someone else's." RN #1 was interviewed by phone on 10/9/24 at 12:44 pm and stated, "[Client C] should have had her own beverage. She knows that. Staff should prompt her to get her own drink." ARD #1 was interviewed by phone on 10/4/24 at 10:20 am and stated, "Staff should prompt [client C] to bring her own drink. She should not drink staff's drink." 3. On 10/2/24 at 6:57 am, client G walked from her bedroom to the kitchen. Direct Support Professional (DSP) #1 was seated in the living room and said good morning to client G. Client G took a fork from a drawer and took several bites from a casserole dish on top of the stove. The casserole was a shared dish prepared for clients A, B, C, D, E, F, G, and H. Client G put the fork in the sink and went back to her bedroom. The stove and kitchen was in direct line of sight from DSP #1's seat in the living room. Client G was not prompted to wash her hands or to serve herself on her own plate. QIDP #1 was interviewed by phone on 10/2/24 at 1:34 pm and stated, "Staff should prompt [client G] to get a plate and a spoon or spatula to get her			

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	own serving instead of eating directly out of the pan." RN #1 was interviewed by phone on 10/9/24 at 12:44 pm and stated, "[Client G] should not eat from the community serving dish. Staff should prompt her to get a plate. She is very comfortable, but staff should prompt them of the guidelines for proper hygiene." ARD #1 was interviewed by phone on 10/4/24 at 10:20 am and stated, "Staff should have reminded [client G] it is not appropriate. I understand they feel like family at home with each other, but it is a facility, and they should be using a plate." 9-3-7(a)			