

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1300 MITCHEL ST ROCHESTER, IN 46975
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for the post-certification revisit (PCR) to the recertification and state licensure survey and to the Covid-19 focused infection control survey completed on 2/5/2021.</p> <p>Dates of survey: 3/11 and 3/12/2021</p> <p>Provider Number: 15G698 Facility Number: 003238 AIM Number: 200371780</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/25/21.</p>	W 0000		
W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on observation, interview, and record review, for 1 of 3 sampled clients (client #8), the facility failed to immediately report client #8's pressure wound to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to State Law.</p> <p>Findings include:</p> <p>On 3/11/2021 from 5:55am until 7:30am, client #8 was observed at the group home and sat in her recliner, sat at the dining room table, did not speak, and wore slippers on her feet. At 6:30am,</p>	W 0153	<p>RM and Nurse was trained on reporting responsibilities on injuries of unknown origin and pressure wounds. (attachment 1)</p> <p>They will be monitored for compliance through weekly monitoring by coordinator.</p> <p>Staff responsible: RM, Nurse, Coordinator</p>	04/02/2021

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 other safeguards 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1300 MITCHEL ST ROCHESTER, IN 46975
--	--

(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
	<p>DSP (Direct Support Professional) #1 and DSP #2 both indicated client #8 had a pressure sore on her foot from wearing shoes. At 6:30am, DSP #1 indicated client #8's pressure sore had come up on her foot over the past week and gone from red to open on 3/8/2021.</p> <p>On 3/11/2021 at 9:30am, a review of the facility's BDDS reports from 2/5/2021 through 3/11/2021 indicated the following incident for client #8.</p> <p>-A 3/11/2021 BDDS report for client #8's pressure sore on 3/8/2021 at 8:00am indicated "[Client #8] has a spot on her left ankle the length is 1.50cm (centimeters) and width is 1cm, cold for temperature, condition is dry, color is red, no odor, no inflammation, surrounding skin is normal pink, and applied bacitracin and a Band-Aid. Nurse notified asked if documented, said yes, keep shoes off, put no pressure, apply bacitracin, and bandage."</p> <p>On 3/11/2021 at 9:30am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility followed the BDDS guidelines for reporting neglect and/or mistreatment immediately to the administrator and to BDDS in accordance to State Law. The QIDP indicated changes in client condition should be reported. The QIDP indicated client #8's open pressure sore was not immediately reported to the administrator and to BDDS in accordance with State Law.</p> <p>On 3/12/2021 at 3:00pm, an interview was conducted with the CSC (Community Supports Coordinator) and the QIDP (Qualified Intellectual Disabilities Professional). The CSC and the QIDP both indicated the facility followed the BDDS guidelines to immediately report to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1300 MITCHEL ST ROCHESTER, IN 46975
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0455 Bldg. 00	<p>administrator and to BDDS in accordance to State Law to prevent the situation from recurring. The CSC indicated the facility staff immediately reported client #8's pressure sore to the RN. The CSC stated "No it was not immediately reported" to the administrator and to BDDS in accordance with State Law.</p> <p>On 3/11/2021 at 9:00am, an interview was conducted with the agency Registered Nurse (RN). The RN stated "I have seen [client #8's] skin wound." The RN indicated client #8's pressure sore was on her left foot/ankle and stated "I believe it to be consistent with the pressure from her shoes." The RN indicated he had assessed the area on 3/11/2021 while the surveyor was in the group home.</p> <p>This deficiency was cited on 2/5/2021. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview for 1 of 3 sampled clients (client #1) and 3 additional clients (clients #5, #6, and #7), the facility failed to ensure the staff to implement and teach sanitary methods around the home and during dining opportunities to assist with preventing the spread of Covid-19 during a pandemic.</p> <p>Findings include:</p>	W 0455	<p>Staff were trained on infectious disease control and handwashing procedures. They were tested for competency (attachment 2, 3)</p> <p>RM, Nurse, and QDP are monitoring for compliance through weekly observations. (attachment 4)</p> <p>Staff responsible: RM, Nurse,</p>	04/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1300 MITCHEL ST ROCHESTER, IN 46975
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During observations on 3/11/2021 from 5:55am until 7:30am, clients #1, #5, #6, and #7 were observed on the men's side of the group home. At 5:55am until 6:45am, client #1 threw and spun bowls on the dining room table, threw items on the floor, bent over in his wheelchair to pick the items up off the floor, and licked his fingers then touched the floor and the dining room table to wipe areas of the floor and dining room table with his fingers. Client #1 was not encouraged to wash his hands each time. From 5:55am until 6:45am, clients #6 and #7 sat in their living room recliners, were asleep, rubbed their faces and body with their hands and no hand washing was encouraged by the facility staff. During the observation period, client #5 walked throughout the group home, rubbed his face with his fingers, opened/closed cabinets and drawers, touched his fingers to the inside of the kitchen sink with dirty dishes in the sink, and did not wash his hands.</p> <p>From 6:45am until 7:15am, clients #1, #5, #6, and #7 were assisted by DSP (Direct Support Professional) #1 to eat their prepared breakfast of breakfast casserole, cereal, and milk and did not wash their hands before eating. At 7:10am, DSP #1 stated clients #1, #5, #6, and #7 "washed their hands when I got them up for the day before 5:55am." DSP #1 indicated clients #1, #5, #6, and #7 did not wash their hands before eating their breakfast. DSP #1 indicated she did not clean the table before clients #1, #5, #6, and #7 ate their breakfast on the dining room table. DSP #1 indicated the facility followed Universal Precautions and Covid-19 training to clean the counter tops and tables routinely and indicated client #1 did touch the table to spin bowls on and off the table before breakfast.</p> <p>On 3/11/2021 at 9:00am, a review of the 4/2019</p>		QDP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1300 MITCHEL ST ROCHESTER, IN 46975
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Cardinal Services Medical Manual sectioned "Preventing the spread of Communicable Diseases" indicated "Sanitize glasses, dishes and silverware, Use paper cups in bathroom, Wash hands before touching clean dishes, Dishwashers sanitize better than hand washing, If you must hand wash, put through bleach rinse and let air dry, Do not expose food to coughing, sneezing, or mishandling."</p> <p>On 3/11/2021 at 9:00am, a review of the 3/27/2020 Cardinal COVID-19 Manual sectioned "Education and Training" indicated "The facility has plans to provide education and training to HCP(Health Care Provider), residents, and family members of residents to help them understand the implications of, and basic prevention and control measures for, COVID-19. The training consists of the health and safety measures Cardinal Services has implemented in response to the pandemic, information regarding signs and symptoms of the virus and how it is spread, and a video demonstration showing how to properly wash hands. A YouTube video demonstrating how to clean groceries brought into the home was placed on Front for all staff on April 4, 2020. Training regarding health and safety measures for the Coronavirus was added to new hire orientation, and each new hire receives a handout with guidelines. A person has been designated with responsibility for coordinating education and training on COVID-19 (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance).Plans and material developed for education and job-specific training of HCP which includes information on recommended infection control measures to prevent the spread of COVID-19, including: Signs and symptoms of respiratory illness, including COVID-19. How to monitor residents for signs and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1300 MITCHEL ST ROCHESTER, IN 46975
--	--

(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
	<p>symptoms of respiratory illness. How to keep residents, visitors, and HCP safe by using correct infection control practices including proper hand hygiene and selection and use of PPE (Personal Protective Equipment). Training should include return demonstrations to document competency. Staying home when ill...."</p> <p>On 3/11/2021 at 9:30am, an interview was conducted with the QIDP (Qualified Intellectual Disability Professional). The QIDP indicated clients should be washing their hands before and after they eat a meal, before and after a medication pass, and when using the restroom. The QIDP indicated all items that are shared within the home should be cleaned regularly per universal precautions, this includes dining items that other clients handle or touch. The QIDP indicated all items which are placed in a client's mouth must be sanitized after.</p> <p>On 3/11/2021 at 9:00am, an interview was conducted with the agency Registered Nurse (RN). The RN indicated the facility staff should encourage clients #1, #5, #6, and #7 to wash their hands before eating to prevent the spread of infection.</p> <p>This deficiency was cited on 2/5/2021. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>			