STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G307	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILD ADULT RESOURCES SRV INC	206 W STATE ST KINGMAN, IN 47952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for a fundamental recertification and state licensure survey. Survey dates: July 18, 19, 23, and 24, 2012. Facility number: 000826 Provider number: 15G307 AIMS number: 100249120 Surveyor: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed July 30, 2012 by Dotty Walton, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement its policy and procedures to prevent client to client abuse (physical aggression) and thoroughly investigate 3 of 3 incidents reviewed for allegations of abuse (clients #1, #5, #6, and #7). Findings include: The facility's policy and procedures were reviewed on 07/18/2012 at 1:40 p.m. The facility's policy, titled, "Abuse-Neglect Policy & Procedure," dated 02/2011, indicated, "...It is C.A.R.S. (Child Adult Resource Services, Inc.) policy to protect all consumers, who receive services, from any form of abuse, neglect, exploitation, mistreatment, bodily harm and/or injury from staff, volunteers or any other consumer affiliated with C.A.R.S....When a reportable incident is the result of a suspicion of abuse, neglect, exploitation, mistreatment of an (sic) consumer or injury of unknown origin - the Division Director will...Initiate an internal investigation...." The facility's reportable incidents were reviewed on 07/18/2012 at 2:50 p.m. An	W0149	Currently CARS has an Abuse-Neglect Policy and Procedure in place. This policy & procedure will be revised by 8/10/2012 to include...Examples of Abuse / Neglect... ii. Client-to-client physical aggression (it will also include) Protection of the Consumer...Initiate an internal investigation - Client-to-Client physical aggression is considered abuse and needs to be investigated. This updated policy and procedure will initiate an internal investigation for all future client-to-client physical aggression. The Director of Adult Services reviews and will continue to review all internal incident reports to determine if an incident report needs to be submitted to the state. The Director of Adult Services will initiate an internal investigation when a report is regarding client-to-client physical aggression. The Director of Adult Services will oversee the entire investigation process.	08/10/2012

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	Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 05/21/2012 at 4:15 p.m., indicated, "...[Client #8] then hit [client #7], scratched him on the L (left) cheek, and grabbed his neck...." The record did not indicate the allegations of client to client abuse had been investigated. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated 05/23/2012 at 3:15 p.m., indicated, "...[Client #5] was escalated over music being played, turning a table over in the area and yelling. This escalated [client #6], who yelled at [client #5]. [Client #5] chased [client #6] down the hall & to the conference area where [client #6] attempted to shut the door on [client #5]. [Client #5] put his hand in the door, causing redness, bruising to knuckles on L (left) middle & ring fingers. [Client #5] pushed open the door & ran after [client #6], grabbing & ripping his shirt. [Client #5] continued to go after [client #6] and grabbed his arm, leaving a light 2" (inch) scratch on [client #6's] arm...." The record did not indicate the allegations of client to client abuse had been investigated. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 05/13/2012 at 3:15 p.m., indicated,			

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	"...[Client #5] and [client #6] were arguing over a song being played. [Client #6] was escalated, yelling at [client #5]. [Client #5] chased [client#6] to conference area, grabbing his shirt, tearing it. [Client #6] ran and grabbed [client #5's] arm, lightly scratching it...." The record did not indicate the allegations of client to client abuse had been investigated. During an interview on 07/18/2012 at 3:25 p.m., Administrative staff #1 indicated the incidents had not been investigated. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to thoroughly investigate 3 of 3 incidents reviewed for allegations of client to client abuse (physical aggression) (clients #1, #5, #6, and #7). Findings include: The facility's reportable incidents were reviewed on 07/18/2012 at 2:50 p.m. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 05/21/2012 at 4:15 p.m., indicated, "...[Client #8] then hit [client #7], scratched him on the L (left) cheek, and grabbed his neck...." The record did not indicate the allegations of client to client abuse had been investigated. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated 05/23/2012 at 3:15 p.m., indicated, "...[Client #5] was escalated over music being played, turning a table over in the area and yelling. This escalated [client #6], who yelled at [client #5]. [Client #5] chased [client #6] down the hall & to the conference area where [client #6] attempted to shut the door on [client #5]. [Client #5] put his hand in the door,	W0154	Currently CARS has an Abuse-Neglect Policy and Procedure in place. This policy & procedure will be revised by 8/10/2012 to include...Examples of Abuse / Neglect... ii. Client-to-client physical aggression (it will also include) Protection of the Consumer...Initiate an internal investigation - Client-to-Client physical aggression is considered abuse and needs to be investigated. This updated policy and procedure will initiate an internal investigation for all future client-to-client physical aggression. The Director of Adult Services reviews and will continue to review all internal incident reports to determine if an incident report needs to be submitted to the state. The Director of Adult Services will initiate an internal investigation when a report is regarding client-to-client physical aggression. The Director of Adult Services will oversee the entire investigation process.	08/10/2012

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	causing redness, bruising to knuckles on L (left) middle & ring fingers. [Client #5] pushed open the door & ran after [client #6], grabbing & ripping his shirt. [Client #5] continued to go after [client #6] and grabbed his arm, leaving a light 2" (inch) scratch on [client #6's] arm...." The record did not indicate the allegations of client to client abuse had been investigated. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 05/13/2012 at 3:15 p.m., indicated, "...[Client #5] and [client #6] were arguing over a song being played. [Client #6] was escalated, yelling at [client #5]. [Client #5] chased [client#6] to conference area, grabbing his shirt, tearing it. [Client #6] ran and grabbed [client #5's] arm, lightly scratching it...." The record did not indicate the allegations of client to client abuse had been investigated. During an interview on 07/18/2012 at 3:25 p.m., Administrative staff #1 indicated the incidents had not been investigated. 9-3-2(a)			

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W0189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review, and interview, the facility failed to ensure all staff who worked with a client were trained in regard to the client's behavioral needs/plan (supplemental client #5). Findings include: During observations on 07/18/2012 at 5:45 p.m., client #5 argued with client #4 while sitting at the dining table. Direct Support Professional (DSP) #4 verbally redirected the clients from yelling at each other. Client #5 picked up his glass and threatened to throw it at client #6. Client #5 stood up from his dining chair and grabbed his ball cap from a card table. Client #5 began hitting client #6 on the top of his head with the ball cap. Client #6 swung his fist at client #5 but did not make contact because House Manager (HM) #1 stepped between the clients and blocked the hit with his body. Direct Support Professional (DSP) #4 encouraged client #6 to leave the area. DSP #4 and client #6 went to the back patio of the house. Client #5 forcefully shoved his dining chair under the table, then tossed a 3 inch binder against the	W0189	On 8/17/2012 - HM#1 will participate and complete the NVCPI (Non-Violent Crisis Prevention Intervention) refresher training presented by Dana Cook – Assistant Director/NVCPI Instructor. This training will give HM#1 the training that enables him to perform his duties effectively, efficiently and competently in regards to resident's behavioral needs and plans. HM#1 will continue to receive CPI refresher classes on an annual basis – this training and all other staff trainings will be tracked and monitored by using a Human Resource training data system. During the monthly Adult Management Team meeting – each Management team member will review and discuss any needed training for specific staff or staff in general. Trainings will be arranged and scheduled based on this meeting.	08/17/2012

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	wall. Client #5 picked up a mop and threw it at HM #1. Client #5 hit HM #1 in the head and tried to put his hands around HM #1's neck. HM #1 positioned himself behind client #5 and placed his arms around client #5's upper chest. HM #1 bent his arms upward so that client #5's arms were secured in the bend of HM #1's elbows. Client #5 pulled away from HM #1 and continued swinging his hat at HM #1 for 5 minutes. HM #1 asked DSP #7 to call Administrative staff #1 to assist with de-escalating client #5. Client #5 shoved the table as he walked towards the group home office. He calmed and returned to the table where he ate his meal at 6:08 p.m. Client #5's record was reviewed on 07/23/2012 at 10:35 a.m. The Social Integration Plan (SIP), dated 01/2012, indicated, "...NVCPI (Non-Violent Crisis Prevention Intervention) will be utilized by staff beginning with verbal de-escalation...NVCPI will only be utilized to ensure [client #5's] or others' immediate safety, beginning with the least restrictive interventions. Only staff that has been formally trained in NVCPI will complete intervention as needed...." Staff training records were reviewed on 07/18/2012 at 2:30 p.m. The record indicated HM #1's CPI (Crisis Prevention			

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	Intervention) certification was current. During an interview on 07/23/2012 at 12:10 p.m., HM #1 indicated he had been trained in (NV)CPI. He stated, "I'm not exactly sure what holds are included in NVCPI. At the time (of the aforementioned incident) I was at a loss and was just trying to keep him (client #5) from hitting others." During an interview on 07/23/2012 at 1:15 p.m., Administrative staff #1 indicated the hold performed by HM #1 was not part of (NV)CPI training. He indicated HM #1 should have followed the guidelines for implementing therapeutic holds taught in (NV)CPI. 9-3-3(a)			

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview, the facility failed to ensure strategies were implemented as written in the Individual Support Plan (ISP) to reduce maladaptive behaviors (supplemental client #5). Findings include: During observations on 07/18/2012 at 5:45 p.m., client #5 argued with client #4 while sitting at the dining table. Direct Support Professional (DSP) #4 verbally redirected the clients from yelling at each other. Client #5 picked up his glass and threatened to throw it at client #6. Client #5 stood up from his dining chair and grabbed his ball cap from a card table. Client #5 began hitting client #6 on the top of his head with the ball cap. Client #6 swung his fist at client #5 but did not make contact because House Manager (HM) #1 stepped between the clients and blocked the hit with his body. DSP #4 encouraged client #6 to leave the area. DSP #4 and client #6 went to the back	W0249	On 8/2/2012 – Bonnie Jeffery (QMRP) re-trained Kingman House staff regarding client #5's Social Integration Plan. Training included: NVCPI will be utilized by staff beginning with verbal de-escalation. Physical NVCPI will only be utilized to ensure SH's and others immediate safety, beginning with least-restrictive interventions. Only staff that has been formally trained in NVCPI will complete intervention as needed. QMRP will continue to train residential staff on an ongoing basis when SIP's are updated or revised in any way. Quality Assurance personnel will assure appropriate staff is being trained on all resident's plans during regular QA reviews. During the monthly Adult Management Team meeting – each Management team member will review and discuss any needed training for specific staff or staff in general. Trainings will be arranged and scheduled based on this meeting.	08/02/2012

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	patio of the house. Client #5 forcefully shoved his dining chair under the table, then tossed a 3 inch binder against the wall. Client #5 picked up a mop and threw it at HM #1. Client #5 hit HM #1 in the head and tried to put his hands around HM #1's neck. HM #1 positioned himself behind client #5 and placed his arms around client #5's upper chest. HM #1 bent his arms upward so that client #5's arms were secured in the bend of HM #1's elbows. Client #5 pulled away from HM #1 and continued swinging his hat at HM #1 for 5 minutes. HM #1 asked DSP #7 to call Administrative staff #1 to assist with de-escalating client #5. Client #5 shoved the table as he walked towards the group home office. He calmed and returned to the table where he ate his meal at 6:08 p.m. Client #5's record was reviewed on 07/23/2012 at 10:35 a.m. The Social Integration Plan (SIP), dated 01/2012, indicated, "...NVCPI (Non-Violent Crisis Prevention Intervention) will be utilized by staff beginning with verbal de-escalation...NVCPI will only be utilized to ensure [client #5's] or others' immediate safety, beginning with the least restrictive interventions. Only staff that has been formally trained in NVCPI will complete intervention as needed...."			

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	During an interview on 07/23/2012 at 12:10 p.m., HM #1 indicated he had been trained in (NV)CPI. He stated, "I'm not exactly sure what holds are included in NVCPI. At the time (of the aforementioned incident) I was at a loss and was just trying to keep him (client #5) from hitting others." During an interview on 07/23/2012 at 1:15 p.m., Administrative staff #1 indicated the hold performed by HM #1 was not part of (NV)CPI training. He indicated HM #1 failed to implement client #5's SIP and should have followed the guidelines for implementing therapeutic holds taught in (NV)CPI. 9-3-4(a)			

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W0262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the facility failed to ensure its Human Rights Committee (HRC) deliberated and discussed plans that included restrictive interventions prior to approving the use of the door alarms for 4 of 4 sampled clients and 4 additional clients reviewed for restrictive program plans (clients #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: The facility's Human Rights Committee (HRC)/Specially Constituted Committee minutes were reviewed on 07/19/12 at 8:30 a.m. The record indicated a door alarm was approved for use on entry/exit doors to the home due to elopement behaviors for client #2. The record indicated phone approval was obtained on 10/04/2011 and the alarms implemented prior to the committee meeting to discuss and deliberate the restriction on 11/28/2011. This alarm affected clients #1, #3, #4, #5, #6, #7, and #8 in addition to the client for which the restriction was recommended (client #2)	W0262	Currently CARS has a Human Rights Committee Policy & Procedure in place. This policy & procedure will be revised by 8/3/2012 to include...When the use of restrictive interventions with an individual and/or other human rights issues for an individual arise between HRC meetings - CARS will seek verbal approval from HRC members. The Director of Adult Services and/or Designee will complete conference calls so that HRC members will have the opportunity to have group discussions about risks versus benefits of medications, restrictive intervention and /or other human rights issues. This updated policy and procedure will prevent HRC members from being telephoned individually. During regular QA reviews, Quality Assurance personnel will review all HRC approvals and assure that all HRC approvals have been completed either by a face-to-face group meetings or by conference calls.	08/03/2012

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	Client #2's record was reviewed on 07/23/2012 at 10:57 a.m. A Social Integration plan (SIP), dated 01/2012, indicated client #2 had tracked behaviors of elopement and attempted elopement. The record indicated door alarms were implemented to alert staff when client #2 exited the group home. During an interview on 07/23/2012 at 1:25 p.m., Administrative staff #1 indicated HRC members were contacted via telephone individually for verbal approval of the door alarms. Administrative staff #1 indicated the door alarms were implemented prior to the committee meeting to discuss and deliberate the use of the alarms. 9-3-4(a)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0315	483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff. Based on record review and interview, the facility failed to ensure clients receiving antipsychotic medications were monitored for extra pyramidal side effects (a group of side effects associated with antipsychotic medications including, but not limited to, restlessness and involuntary muscle movements) for 1 of 4 sampled clients (client #2). Finding include: Client #2's record was reviewed on 07/23/2012 at 10:57 a.m. The physician's "Recertification Form," dated 05/09/2012, and identified by the facility nurse as current, indicated client #2 was taking Abilify (antipsychotic) 7.5 mg (milligrams) twice daily. The record did not indicate regular screening for extra pyramidal side effects had been completed during the past year. During an interview on 07/23/2012 at 1:25 p.m., the facility RN indicated she was unable to locate documentation to indicate client #2 was screened for extra pyramidal side effects related to use of antipsychotic medications.	W0315	CARS currently has a form called Tardive Dyskinesia Symptoms AIMS (Abnormal Involuntary Movement Scale) - Examination Procedure. This form was completed on residents of the Kingman House on 7/25/2012 by the Agency Nurse. From this point on - the AIMS form will be completed by the Agency Nurse on a quarterly basis for all appropriate CARS group home residents to screen for extra pyramidal side effects related to the use of antipsychotic medications. During regular QA reviews, Quality Assurance personnel will assure that AIMS forms have been completed and filed in a timely manner on all appropriate residents.	07/25/2012

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	9-3-5(a)			

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W0323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed to ensure an annual physical, which included a vision evaluation, was completed for 2 of 4 sampled clients (clients #2 and #4). Findings include: 1. Client #3's record was reviewed on 07/23/2012 at 10:43 a.m. There was no documentation in the client's record to indicate a vision screening had been completed during the past year. 2. Client# #4's record was reviewed on 07/23/2012 at 9:50 a.m. There was no documentation in the client's record to indicate a vision screening had been completed during the past year. During an interview on 07/23/2012 at 12:55 p.m., the facility RN indicated vision screening should have been completed and documented on client #3's and #4's annual physical forms. 9-3-6(a)	W0323	C.A.R.S. Agency Nurse has obtained an Insta-Line Visual Acuity Instrument that will be used to complete vision screenings on all residents annually and/or as the need arises. Visual screenings for the Kingman House residents will be completed by the Agency Nurse by 8/23/2012. During regular QA reviews, Quality Assurance personnel will assure that visual screenings have been completed and filed in a timely manner on all residents.	08/23/2012

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W0325	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. Based on record review and interview, the facility failed to ensure physician recommendations for routine laboratory and health screening tests were implemented for 2 of 4 sampled clients (clients #2 and #4). Findings include: 1. Client #2's record was reviewed on 07/23/2012 at 10 :57 a.m. The physician's recertification form, dated 05/09/2012, and identified as current, indicated, "...Annually - Chest x-ray for TB (tuberculosis) screen, CBC (complete blood count), CMP (comprehensive metabolic panel)...." The record did not include documentation to indicate the physician's recommendations had been implemented during the past year. 2. Client #4's record was reviewed on 07/23/2012 at 9:50 a.m. The physician's recertification form, dated 05/09/2012, and identified as current, indicated, "...Lab At (sic) least annually CBC, CMP...." The record did not include documentation to indicate the physician's	W0325	C.A.R.S. Agency Nurse has been communicating with the physician and Client #2 will receive a chest x-ray for TB (tuberculosis) screening, CBC (complete blood count) and CMP (comprehensive metabolic panel) by 8/23/2012. C.A.R.S. Agency Nurse has been communicating with the physician and Client #4 will receive a CBC (complete blood count) and CMP (comprehensive metabolic panel) by 8/23/2012. During regular QA reviews, Quality Assurance personnel will work with the Agency Nurse to assure that all necessary tests and labs have been completed and filed in a timely manner on all appropriate residents.	08/23/2012

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	recommendations had been implemented during the past year. During an interview on 07/23/2012 at 1:20 p.m., the facility RN indicated she was not able to locate documentation to indicate the laboratory tests/chest x-ray had been obtained as recommended by the physician for clients #2 and #4. 9-3-6(a)			

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W0381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview, the facility failed to ensure the medication cabinet was locked when unattended by staff while 4 of 4 sampled clients (clients #1, #2, #3, #4) and 4 additional clients were present in the group home (clients #5, #6, #7, and #8). Findings include: During observations on 07/19/2012 at 6:30 a.m., Direct Support Professional (DSP) #7 left the medication cabinet unlocked and unattended for 1 minute after passing medications to client #1. The cabinet was left unlocked and unattended an additional minute at 6:50 a.m. after DSP #7 passed medications to client #4. During an interview on 07/19/2012 at 7:20 a.m., DSP #7 indicated she should have locked the medication cabinet when she walked away from the area. During an interview on 07/23/2012 at 1:25 p.m., the facility RN indicated the medication cabinet should not have been left unlocked and unattended by staff.	W0381	On 8/2/2012 - during CARS monthly Residential In-service - all residential staff will be trained on keeping medications locked at all times. The CARS Residential In-Service Schedule also consists of Medication Administration that will be presented again in January 2013 or sooner if needed before this date. - All residential staff will continue to receive general and specific training about Medication Administration on an ongoing basis. This training and all other staff trainings will be tracked and monitored by using a Human Resource training data system. - During the monthly Adult Management Team meeting – each Management team member will review and discuss any needed training for specific staff or staff in general. Trainings will be arranged and scheduled based on this meeting.	08/02/2012

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W0486	483.480(d)(4) DINING AREAS AND SERVICE The facility must direct self-help dining procedures. Based on observation and interview, the facility failed to encourage clients to participate in family style dining to the extent they were capable for 1 of 4 sampled clients (client #4). Findings include: During observations on 07/18/2012 at 5:45 p.m., client #4 sat at a table located on the group home patio after confrontation with a peer. Direct Support Professional (DSP) #4, who had accompanied client #4 to the patio, entered the dining area at 6:00 p.m. and indicated client #4 wanted to eat his meal on the patio. DSP #4 custodially prepared a plate with menu items, then took the plate to the patio where he gave it to client #4. During an interview on 07/23/2012 at 1:05 p.m., Administrative staff #1 indicated client #4 was capable of filling his plate and should have been encouraged to serve himself. 9-3-8(a)	W0486	On 8/2/2012 - during CARS monthly Residential In-service - all residential staff will be trained on directing self-help dining procedures. The CARS Residential In-Service Schedule also consists of Family Style Dining that will be presented again in October 2012. - All residential staff will continue to receive general and specific training about Family Style Dining on an ongoing basis. This training and all other staff trainings will be tracked and monitored by using a Human Resource training data system. - During the monthly Adult Management Team meeting – each Management team member will review and discuss any needed training for specific staff or staff in general. Trainings will be arranged and scheduled based on this meeting.	08/02/2012

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W9999	STATE FINDINGS: 1. The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-3 Facility Staffing Sec. 3(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based on record review and interview, the facility failed to obtain yearly PPDs and/or a chest x-ray and/or annual	W9999	On 7/20/2012 - DSP#1 completed an Annual TB Test at Union Hospital Center for Occupational Health in Terre Haute, IN. Test results showed negative for TB. During monthly QA reviews, Quality Assurance personnel will review random employee files to assure all necessary documentation has been completed and filed in a timely manner.	07/31/2012

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	tuberculosis screening for 1 of 5 sampled staff (Direct Support Professional #1). Findings include: Employee records were reviewed on 07/18/2012 at 2:30 p.m. The record indicated Direct Support Professional (DSP) #1's chest x-ray, dated 05/27/2011, was negative for active pulmonary disease. The record did not include documentation to indicate DSP #1 had an annual tuberculosis risk assessment or chest x-ray during the past year. During an interview on 07/23/2012 at 1:10 p.m., Administrative staff #1 indicated the annual tuberculosis risk assessment or annual chest x-ray had been completed during the past year. 9-3-3(e)			