

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/25/2011
NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN46953		
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W0000	<p>This visit was a post-certification revisit to a fundamental annual recertification and state licensure survey conducted on August 16, 2011.</p> <p>Dates of survey: October 24 and 25, 2011.</p> <p>Facility Number: 001095 Provider Number: 15G581 AIM Number: 100245560</p> <p>Surveyor: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W0000			
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>	W0249	Carey Services must assure that continuous active treatment takes place for each client served. The facility failed to meet this standard, as evidenced by the observation of missed	11/14/2011	

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>opportunities during the survey. Carey Services failed to correct this standard upon re-survey.</p> <p><u>CORRECTION</u> Due to the ineffectiveness of the training given to staff after the original survey, new training was implemented, stressing active treatment and giving specific examples of formal and informal medication goals. Specific findings were discussed, and examples given of alternative ways to administer meds that include consumer training and participation.</p> <p><u>PREVENTION</u> Additional training was given to supplement the specific training noted above. The training was based on "The Active Treatment Loop," originally developed by Catherine Hays. At each staff meeting, active treatment will be discussed, allowing staff to creatively identify informal opportunities and to assure that any changes to formal goals are known. Additionally, a list of medication-related goals will be given to staff, and a list of possible informal goals will be posted to keep required interventions top-of-mind.</p> <p><u>MONITORING</u> 25% of all med passes will be observed by the manager, QMRP, or nurse, to assure that medication goals are being appropriately run, and to assist in the identification of informal opportunities to train. This will continue for a period of three months, at which point the</p>		

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	<p>Based on observation, record review, and interview the facility failed to assure medication administration objectives were implemented for 3 of 3 clients (clients #1, #2 and #4) who received medication at the 4:00 PM and 5:00 PM medication pass.</p> <p>Findings include:</p> <p>On 10/24/11 from 4:06 PM until 4:10 PM and from 4:50 PM until 4:53 PM, medication administration was observed at the group home administered by staff #2.</p> <p>1. On 10/24/11 at 4:06 PM, staff #2 punched client #4's Oxcarbazepin (anticonvulsant) and Lorazepam (for anxiety) into a medication cup. Client #2 ingested the medication and left the room. No teaching/training of the names, reasons, or doses of medication was observed.</p> <p>At 4:50 PM, staff #2 punched client #4's Carb/Levo ER (for Parkinson-like symptoms - shakiness, stiffness & difficulty moving) and Simvastin (for high cholesterol) into a medication cup.</p>		<p>practice will be re-evaluated based on employee compliance. The QMRP will continue to monitor the frequency of intervention to assure that active treatment is maintained.</p>		

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	<p>Client #2 ingested the medication and left the room. No teaching/training of the names, reasons, or doses of medication was observed.</p> <p>Client #4's records were reviewed on 10/25/11 at 8:30 AM. Client #4's ISP (Individual Support Plan) dated 09/16/11 contained a goal which indicated client #4 was to wash his hands before each medication pass.</p> <p>On 10/25/11 at 10:05 AM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated client #1's medication administration should include medication training.</p> <p>2. On 10/24/11 at 4:10 PM, staff #2 punched client #1's Propranolol (for hypertension) into a medication cup and then poured the medication into pudding. Client #1 was fed the pudding with the pill by staff #2 and left the room. No teaching/training of the names, reasons, or doses of medication was observed.</p> <p>Client #1's records were reviewed on 10/25/11 at 8:45 AM. Client #1's ISP (Individual Support Plan) dated 10/13/11 contained a goal which indicated client #1 was to put the medication in the pudding.</p>						

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	<p>On 10/25/11 at 10:05 AM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated client #1's medication administration should include training and objectives should have been implemented during medication administration.</p> <p>3. On 10/24/11 at 4:53 PM, staff #2 punched client #2's Sulindac (anti-inflammatory) into a medication cup and client #2 ingested the medication. Staff #2 then administered a topical gel (Voltraren Gel 1% for joint pain) to client #2's left knee. No teaching/training of the names, reasons, or doses of medication was observed.</p> <p>Client #2's records were reviewed on 10/25/11 at 9:00 AM. Client #2's ISP (Individual Support Plan) dated 10/19/11 contained a goal which indicated client #2 was to state the name and purpose of her medications at medication pass.</p> <p>On 10/25/11 at 10:05 AM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated client #2's medication administration should include training and objectives should have been implemented during medication administration.</p>				

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	This deficiency was cited on August 16, 2011. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)				
W0369	The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W0369	Carey Services must assure that medications are administered without error. Specifically, a medication that was labeled as requiring administration with food was given without food for 60 minutes. Carey Services failed to correct this standard upon re-survey. <u>CORRECTION</u> Staff were retrained on the necessity of carefully following physician orders, and specifically medications that must be taken with food. The DSP that failed to give the medication with food was counseled and given additional training. <u>PREVENTION</u> As there was no change in mealtimes, the medication error was determined to be the result of the employee being distracted.	11/14/2011	

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	<p>Based on observation, record review and interview for 2 of 7 medication doses administered at the 4:00 PM and 5:00 PM medication administration, the facility failed to ensure staff administered client medication (clients #2 and #4), as ordered without error.</p> <p>Findings include:</p> <p>On 10/24/11 from 4:06 PM until 4:10 PM and from 4:50 PM until 4:53 PM, medication administration was observed at the group home administered by staff #2.</p> <p>1. On 10/24/11 at 4:06 PM, staff #2</p>		<p>Reminders for clients with medications to be taken with food will be placed on the medication cart as an added precaution against omitting this step. Saltine crackers and other snacks will be stocked on the medication cart as well, and will be given with the medication, regardless of when the next mealtime is to take place. <u>MONITORING</u> 25% of all med passes will be observed by the manager, QMRP, or nurse, to assure that medication that requires food is administered correctly. This will continue for a period of three months, at which point the practice will be re-evaluated based on employee compliance.</p>		

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	<p>punched client #4's Oxcarbazepin (anticonvulsant) into a medication cup. The medication was labeled, "Oxcarbazepin 600 mg (milligram); take one tablet 3 times daily with food. Client #4 ingested the medication and left the room. No food was given to client #4 with the medication. Client #4 was observed to have arrived home at 3:34 PM and ingested no food until he was observed to eat supper at 5:25 PM, a total of 1 hour and 29 minutes after taking the medication.</p> <p>2. On 10/24/11 at 4:53 PM, staff #2 punched client #2's Sulindac (anti-inflammatory) into a medication cup and client #2 ingested the medication. The medication was labeled, "Sulindac 200 mg; give 1 tab by mouth twice daily with meals. The medication card contained a label which read, "take with food." Client #2 received no food with the medication. Client #2 was observed to have arrived home at 3:34 PM and ingested no food until she was observed to eat supper at 5:25 PM, a total of 32 minutes after taking the medication.</p> <p>On 10/25/11 at 10:05 AM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated staff knew they were to give food with client #2's and</p>				

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	<p>client #4's medication and they should have done so at the time of the medication administration.</p> <p>This deficiency was cited on August 16, 2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				