STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREY SERVICES INC	615 E NORTH ST HARTFORD CITY, IN 47348

(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
W000000	This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00143977. Complaint #IN00143977: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149 and W186. Dates of survey: 3/24, 3/25, and 3/26/2014. Surveyor: Susan Eakright, QIDP Facility Number: 000644 Provider Number: 15G107 AIMS Number: 100234170 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed April 3, 2014 by Dotty Walton, QIDP.	W000000	W000 Annual recertification and complaint IN00143977	

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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	15G107	A. BUILDING 00 B. WING	03/26/2014

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W000149	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, for 1 of 3 allegations (client A) reported and for 1 of 29 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility neglected to implement its Abuse, Neglect, and/or Mistreatment policy and procedure to immediately report an allegation of staff to client abuse for client A to the administrator and to BDDS in accordance with state law and neglected to ensure staff were available and supervised client A on the van for his identified behavioral needs. Findings include: 1. On 3/24/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 03/1/13 through 03/24/14. The review indicated the following for client A. -A 1/30/14 BDDS report for an incident reported on 1/30/14 at 10:14am. The BDDS report indicated client A "was upset because a (different) client had a behavior (at the group home) and (that client) was allowed to go to life skills (classroom at the agency owned	W000149	This item outlines that the agency failed to implement its Abuse, Neglect and/or Mistreatment policy and procedure to immediately report an allegation of staff-to-client abuse: Staff Training will occur on Carey Services Policy #5.13 on Abuse, Neglect and Mistreatment by 4/25/2014. This training will cover all possible residents. Specific emphasis will be given on the requirement to **immediately** report. All staff will be expected to follow the agency's policies and procedures. Failure to follow agency policy and procedure will result in progressive disciplinary action up to and including termination of employment. For Client A, the safety plan has been updated in relation to transportation and indicates that "Due to the history of Client A's physical aggression on the van it is decided that if other clients are being transported on the van with Client A then 2 staff will be on the van for the safety of all." All applicable staff will be trained on this update by 4/25/2014. If staff should fail to follow safety protocol, progressive disciplinary action up to and including termination of employment will occur.	04/25/2014

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	workshop). [Client A] cannot go to workshop if [client A] has a behavior due to his threatening to hit the staff with his cane, getting (standing) up in the van, while they are transporting to life skills. [Client A] is required to sit in the back of the van (during transport to the workshop)." The report indicated the Residential Manager (RM) "talked to [client A] before [client A] left (the group home) and he seemed fine. When [client A] arrived at workshop he proceeded to yell at his (workshop) supervisor and hit his cane on the table." The report indicated the RM "received a call from his (workshop) supervisor asking to come get [client A] because she could not have him there (at the workshop) due to [client A's] behaviors. [The RM] had [Group Home Staff #2 (GHS)] (on the facility van) turn around and go back (to the workshop) to pick up [client A]. On the way home [client A] was upset that he couldn't stay and about his pay checks (sic), lack of work, and how bad a supervisor [name] was. When they got about five (5) blocks from the (group) home on the corner of [State Road and Street name], [GHS #2] noticed that [client A] had gotten up out of his seat and was walking toward the front of the van. She pulled the van over as instructed in previous inservice and asked [client A] what he was doing. He said he			

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	was getting out of the van. He got out of (the) van and sat in a snow drift. At 10:11am (sic), [GHS #2] called [the RM] and told (her) what happened." The report indicated the RM arrived by her car on the scene, client A had gotten back into the van, and the RM "followed the van to the group home." The report indicated client A continued to have behaviors at the group home. -A 8/22/13 BDDS report for an incident on 8/22/13 at 7:30am indicated client A was riding in the back of the van and became upset at staff because another client was riding in the front seat of the van. The report indicated client A "unbuckled his seat belt, moved to the front of the van with his cane" as the van was moving. Client A "was acting in an aggressive manner as if he was going to physically hit the staff or the other consumer riding on the van with his cane." -A 8/21/13 at 7:15am, incident report was reviewed for client A. The 8/21/13 incident report indicated one staff with unidentified "consumers" and client A left the group home on the van. The incident report indicated the one (1) staff driving the van looked into the "view mirror [staff] saw [client A] walking from the back of the van aggressively w/			

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	(with) his cane. Staff felt that [client A] was going to hit her with the cane. Staff told [client A] that she was going to call the police. [Client A] kept coming. Staff swerved when [client A] got behind her trying to protect (her) self...When staff swerved (driving the van) [client A] lost his balance. [Client A] bumped up against [client B's] left arm and then backwards and to [client A's] right towards the side van door. Staff pulled off to side road (at) [intersection of State Road and State Road]." The incident report indicated client A continued to argue with the one staff and client B on the van. The staff called for assistance and the RM arrived on the scene and transported client A. On 3/24/14 at 11:00am, GHS #2's witness statement for 1/30/14 was reviewed and indicated the same information as the BDDS 1/30/14 report. On 3/24/14 at 11:00am, the RM's witness statement for the 1/30/14 incident was reviewed. The RM stated "While in the office (on 1/30/14) [client A] said he was trying to kill himself." On 3/24/14 at 1:30pm, an interview with the RM was conducted. The RM stated she arrived on the scene where the van had stopped on 1/30/14 and "[clients A			

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	and B] and one (1) staff were on the van" during the 1/30/14 incident. On 3/25/14 at 2:30pm, an interview with the RM and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RM indicated during the 1/30/14 incident there was one "staff as the driver" of the van present with clients A and B on the van. The QIDP stated "any time [client A] needed to be transported" after calming from physical aggression such as the incident on 1/30/14 "two (2) staff should have been present on the van if another client was present on the van." The QIDP indicated one staff was on the van. On 3/25/14 at 4:58pm, an interview with the QIDP was conducted. The QIDP indicated there was "only one staff on the van for the 1/30/14 incident but the staff immediately followed the transportation procedures dated 9/5/13 by not transporting [client A] any further, calling for assistance, waiting for the [RM] to arrive to assist and [client A] calming." On 3/25/14 at 4:58pm, a review of client A's 9/5/13 "Transportation Procedure Clarification" was conducted. The procedure indicated "Staff personnel will not transport consumers in the midst of inappropriate dangerous behaviors. If a			

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	dangerous behavior occurs after transportation has already begun, staff personnel may pull over and wait until it is safe to resume. Staff personnel will bring consumers home after an aggressive behavior when able to do so logistically...After an act of physical aggression and/or threat of physical aggression, transportation will not be provided for that specific consumer for 24 hours to any destination considered to be a privilege." Client A's transportation safety guidelines did not indicate client A was to sit on the back seat of the van and did not indicate how many staff should be on the van to supervise client A after an act of physical aggression. On 3/26/14 at 10am, an interview with the QIDP and the RM was conducted. The QIDP indicated she did not identify neglect because on 1/30/14 the one staff on the van pulled the van over on the side of the road after client A got out of his seat. The QIDP indicated the staff person followed the transportation safety plan for client A. The RM indicated there were two (2) clients on the van on 1/30/14, clients A and B with one (1) staff person driving the van. The QIDP stated "if there was (sic) two clients on the van then there should have been two staff" to transport client A safely because of his aggressive behaviors. The QIDP and the			

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	RM both indicated client A had incidents of physical aggression on the van on 1/30/14, 8/22/13, and 8/21/13. 2. On 3/24/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 03/1/13 through 03/24/14. The review indicated the following for client A: -A 5/14/13 BDDS report for an incident reported on 5/13/13 at 4:30pm. The BDDS report indicated client A had went to Discharged Employee (DE) #9 in the living room of the group home to ask DE #9 a question. The report indicated DE #9 sat in a recliner watching television with headphones on, client A spoke to DE #9, and DE #9 did not answer. The report indicated client A spoke to DE #9 a "second time," DE #9 did not answer, and client A touched DE #9. Client A "then asked [DE #9] to wake him (client A) up at a certain time. When [client A] woke up it was past (the) time for him to get up. [Client A] went out and asked [DE #9] why he didn't wake [client A] up." The report indicated DE #9 "said that he (client A) was a f----- (expletive) adult and he could wake himself up. [DE #9] also stated that he didn't have anybody to wake him up." The report indicated the Residential Manager (RM) was notified of this incident on 5/13/13 at 4:30pm and DE #9 was suspended			

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	pending an investigation. -A 6/12/13 Follow up BDDS report indicated "The allegation of verbal abuse was substantiated based on the reliability of the witness statements and [DE #9's] previous pattern of behaviors. [DE #9] is clearly a disengaged employee who exhibits a hostile attitude toward [the Agency Name] and its staff...." -The 5/14/13 "Investigative Report" indicated GHS (Group Home Staff) #3 "reported to the [RM] that she witnessed coworker [DE #9] become verbally abusive with consumer [client A]. [DE #9] has been investigated previously for similar circumstances and has received a last chance written warning." The investigation included GHS #3's witness statement which indicated "[GHS #3] reported that she was working with [DE #9] on 3rd shift in the early morning of Sunday, May the 12th (sic) (2013). [GHS #3] reports that [client A] had asked [DE #9] to get him up at a specific time around 7am so he could get ready for church. [GHS #3] further reported that [DE #9] was sitting on the sofa listening to his headphones and [client A] had to ask twice and then finally reach out (sic) and tap [DE #9] on the shoulder to get his attention." GHS #3 indicated she was in the laundry area, "heard a conflict			

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	between [client A] and [DE #9] where she hear [client A] ask [DE #9] why he couldn't wake him up when he asked. [GHS #3] reported that she very clearly heard [DE #9] tell [client A] he was a f------ (expletive) adult and that he can wake himself up and that [DE #9] does not have anyone to wake him [DE #9] up in the morning." The investigation indicated GHS #3 indicated DE #9 "uses profanity primarily the F (expletive) in nearly every sentence. [GHS #3] states that [DE #9] nearly always sits on the sofa and listens to music and very rarely helps with any of the 3rd shift chores." On 3/25/14 at 2:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Residential Manager (RM) was conducted. The QIDP and the RM both stated the incident on 5/13/13 with client A and DE #9 "was substantiated abuse" by staff at the group home. The QIDP indicated staff did not report the 5/13/13 morning allegation until the evening of 5/13/13. The QIDP indicated the facility staff did not protect client A from further staff verbal abuse when they failed to immediately report the incident to the administrator. The QIDP indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect and/or mistreatment. The RM and QIDP			

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	both indicated when they became aware of the incident they took immediate action. The QIDP indicated DE #9 finished his shift of work on 5/13/13 at the group home and the GHS #3 did not report the allegation until 4:30pm. The facility's records were reviewed on 03/24/14 at 12:18pm. A review of the facility's policy on, 6/15/11 "Abuse, Neglect, and Exploitation" indicated, "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible abusive treatment, negligence, or exploitation on the part of staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency....Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and equipment (as indicated in the ISP (Individual Support Plan)." The facility's 6/2011 "Procedures for Reporting abuse, neglect, and other Reportable or Unusual Incidents" indicated "As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and			

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	exploitation...Staff and volunteers are provided training and/or tested for competency on an annual basis regarding their responsibilities in reporting such incidents to authorities as well as to agency administrators immediately upon learning of the suspected abuse/neglect/exploitation." The policy indicated reportable incidents are "1. Any alleged, suspected, or actual abuse, neglect, or exploitation of a consumer." This federal tag relates to complaint #IN00143977. 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on record review and interview, for 1 of 3 allegations reported to BDDS (Bureau of Developmental Disabilities Services) reviewed (client A), the facility failed to immediately report a substantiated allegation of staff to client abuse to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. Findings include: On 3/24/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 03/1/13 through 03/24/14. The review indicated the following for client A. -A 5/14/13 BDDS report for an incident reported on 5/13/13 at 4:30pm. The BDDS report indicated client A had went to Discharged Employee (DE) #9 in the living room of the group home to ask DE #9 a question. The report indicated client A "asked [DE #9] to wake him (client A) up at a certain time. When [client A]	W000153	**W153 Staff Treatment of Clients** This item outlines that the agency failed to immediately report a substantiated allegation of staff-to-client abuse. The plan of correction for this tag is as follows: · Staff Training will occur on Carey Services Policy #5.13 on Abuse, Neglect and Mistreatment by 4/25/2014. This training will cover all possible residents. Specific emphasis will be given on the requirement to immediately report. All staff will be expected to follow the agency's policies and procedures. Failure to follow agency policy and procedure will result in progressive disciplinary action up to and including termination of employment.	04/25/2014

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	woke up it was past (the) time for him to get up. [Client A] went out and asked [DE #9] why he didn't wake [client A] up." The report indicated DE #9 "said that he (client A) was a f-----(expletive) adult and he could wake himself up. [DE #9] also stated that he didn't have anybody to wake him up." The report indicated the Residential Manager (RM) was notified of this incident on 5/13/13 at 4:30pm and DE #9 was suspended pending an investigation. -The 5/14/13 "Investigative Report" indicated GHS (Group Home Staff) #3 "reported to the [RM] that she witnessed coworker [DE #9] become verbally abusive with consumer [client A]." The investigation included GHS #3's witness statement which indicated "[GHS #3] reported that she was working with [DE #9] on 3rd shift in the early morning of Sunday, May the 12th (sic) (2013). [GHS #3] reports that [client A] had asked [DE #9] to get him up at a specific time around 7am so he could get ready for church. [GHS #3] further reported that [DE #9] was sitting on the sofa listening to his headphones and [client A] had to ask twice and then finally reach out (sic) and tap [DE #9] on the shoulder to get his attention." GHS #3 indicated she was in the laundry area, "heard a conflict between [client A] and [DE #9] where			

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	she hear [client A] ask [DE #9] why he couldn't wake him up when he asked. [GHS #3] reported that she very clearly heard [DE #9] tell [client A] he was a f------ (expletive) adult and that he can wake himself up and that [DE #9] does not have anyone to wake him [DE #9] up in the morning." On 3/25/14 at 2:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Residential Manager (RM) was conducted. The QIDP and the RM both stated the incident on 5/13/13 with client A and DE #9 "was substantiated abuse" by staff at the group home. The QIDP indicated staff did not report the 5/13/13 morning allegation until 4:30pm on the evening of 5/13/13. The QIDP indicated the facility staff did not protect client A from further staff verbal abuse when they failed to immediately report the incident to the administrator. The QIDP indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect and/or mistreatment by failing to immediately report the allegation. 9-3-1(b)(5) 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/26/2014

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W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review, and interview, for 1 of 3 sampled clients (client A), the facility failed to provide sufficient staff when transporting client A on the facility van to prevent the potential of physical aggression based on client A's history of aggressive behaviors during transport. Findings include: On 3/24/14 at 7:25am, clients A, B, C, and D left the group home with the one facility staff, Group Home Staff (GHS) #2, on the facility van to go to the agency owned workshop. On 3/24/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 03/1/13 through 03/24/14. The review indicated the following for client A. -A 1/30/14 BDDS report for an incident reported on 1/30/14 at 10:14am. The	W000186	**W186 Direct Care Staff** This item outlines that the agency failed to provide sufficient staff when transporting Client A on the facility van to prevent the potential of physical aggression based on Client A's history of aggressive behaviors during transport. The plan of correction for this tag is as follows: ·For Client A, the safety plan has been updated in relation to transportation and indicates that Due to the history of Client A's physical aggression on the van it is decided that if other clients are being transported on the van with Client A then 2 staff will be on the van for the safety of all. All applicable staff will be trained on this update by 4/25/2014. If staff should fail to follow safety protocol, progressive disciplinary action up to and including termination of employment will occur.	04/25/2014

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	BDDS report indicated client A "was upset because a (different) client had a behavior (at the group home) and (that client) was allowed to go to life skills (classroom at the agency owned workshop). [Client A] cannot go to workshop if [client A] has a behavior due to his threatening to hit the staff with his cane, getting up in the van, while they are transporting to life skills. [Client A] is required to sit in the back of the van (during transport to the workshop)." The report indicated the Residential Manager (RM) "talked to [client A] before [client A] left (the group home) and he seemed fine. When [client A] arrived at workshop he proceeded to yell at his (workshop) supervisor and hit his cane on the table." The report indicated the RM "received a call from his (workshop) supervisor asking to come get [client A] because she could not have him there (at the workshop) due to [client A's] behaviors. [The RM] had [Group Home Staff #2 (GHS)] (on the facility van) turn around and go back (to the workshop) to pick up [client A]. On the way home [client A] was upset that he couldn't stay and about his pay checks (sic), lack of work, and how bad a supervisor [name] was. When they got about five (5) blocks from the (group) home on the corner of [State Road and Street intersection], [GHS #2] noticed that [client A] had			

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	gotten up out of his seat and was walking toward the front of the van. She pulled the van over as instructed in previous inservice and asked [client A] what he was doing. He said he was getting out of the van. He got out of (the) van and sat in a snow drift. At 10:11am (sic), [GHS #2] called [the RM] and told what happened." The report indicated the RM arrived by her car on the scene, client A had gotten back into the van, and the RM "followed the van to the group home." The report indicated client A continued to have behaviors at the group home. -A 8/22/13 BDDS report for an incident on 8/22/13 at 7:30am indicated client A was riding in the back of the van and became upset at staff because another client was riding in the front seat of the van. The report indicated client A "unbuckled his seat belt, moved to the front of the van with his cane" as the van was moving. Client A "was acting in an aggressive manner as if he was going to physically hit the staff or the other consumer riding on the van with his cane." -A 8/21/13 at 7:15am, incident report was reviewed for client A. The 8/21/13 incident report indicated one staff with unidentified "consumers" and client A left the group home on the van. The			

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	incident report indicated in the one (1) staff driving the van looked into the "view mirror [staff] saw [client A] walking from the back of the van aggressively w/ (with) his cane. Staff felt that [client A] was going to hit her with the cane. Staff told [client A] that she was going to call the police. [Client A] kept coming. Staff swerved when [client A] got behind her trying to protect (her) self...When staff swerved (driving the van) [client A] lost his balance. [Client A] bumped up against [client B's] left arm and then backwards and to [client A's] right towards the side van door. Staff pulled off to side road (at) [State Road and State Road]." The incident report indicated client A continued to argue with the one staff and client B on the van. The staff called for assistance and the RM arrived on the scene and transported client A. On 3/24/14 at 11:00am, GHS #2's witness statement for 1/30/14 was reviewed and indicated the same information as the BDDS 1/30/14 report. On 3/24/14 at 11:00am, the RM's witness statement for the 1/30/14 incident was reviewed. The RM stated "While in the office (on 1/30/14) [client A] said he was trying to kill himself."			

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	On 3/24/14 at 1:30pm, an interview with the RM was conducted. The RM stated she arrived on the scene where the van had stopped on 1/30/14 and "[clients A and B] and one (1) staff were on the van" during the 1/30/14 incident. On 3/25/14 at 2:30pm, an interview with the RM and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RM indicated during the 1/30/14 incident there was one "staff as the driver" of the van present with clients A and B on the van. The QIDP stated "any time [client A] needed to be transported" after calming from physical aggression such as the incident on 1/30/14 "two (2) staff should have been present on the van if another client was present on the van." The QIDP indicated one staff was on the van. On 3/25/14 at 4:58pm, an interview with the QIDP was conducted. The QIDP indicated there was "only one staff on the van for the 1/30/14 incident but the staff immediately followed the transportation procedures dated 9/5/13 by not transporting [client A] any further, calling for assistance, waiting for the [RM] to arrive to assist and [client A] calming." On 3/26/14 at 10am, an interview with the QIDP and the RM was conducted.			

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	The QIDP indicated she did not identify the facility's failure to provide supervision because on 1/30/14 the one staff on the van pulled the van over on the side of the road after client A got out of his seat on the van. The QIDP indicated the staff person followed the transportation safety plan for client A. The RM indicated there were two (2) clients on the van on 1/30/14, clients A and B with one (1) staff person driving the van. The QIDP stated "if there was (sic) two clients on the van then there should have been two staff" to transport client A safely because of his aggressive behaviors. The QIDP and the RM both indicated client A had incidents of physical aggression on the van on 1/30/14, 8/22/13, and 8/21/13. On 3/25/14 at 4:58pm, a review of client A's 9/5/13 "Transportation Procedure Clarification" was conducted. The procedure indicated "Staff personnel will not transport consumers in the midst of inappropriate dangerous behaviors. If a dangerous behavior occurs after transportation has already begun, staff personnel may pull over and wait until it is safe to resume. Staff personnel will bring consumers home after an aggressive behavior when able to do so logistically...After an act of physical aggression and/or threat of physical aggression, transportation will not be provided for that specific consumer for 24 hours to any destination considered to be a privilege." Client A's transportation safety guidelines did not indicate client A was to sit on the back seat of the van and did not indicate how many staff should be			

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	on the van to supervise client A after an act of physical aggression. Client A's record was reviewed on 3/25/14 at 10:45am. Client A's 3/4/13 ISP (Individual Support Plan) and client A's 4/2013 BSP (Behavior Support Plan) both indicated targeted behaviors of Anger Outbursts which included Suicidal Ideation, verbal aggression, physical aggression, and non compliance. Client A's BSP indicated he had a history of talking about suicide and planning his suicide. Client A's record indicated he was admitted to the facility on 3/11/13. Client A's diagnosis included but was not limited to: Mild Mental Retardation, Major Depression, PTSD (Post Traumatic Stress Disorder), Anxiety Disorder, and Borderline Personality Disorder. This federal tag relates to complaint #IN00143977. 9-3-3(a)			

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W000218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview, for 1 of 3 sampled clients (client B) who were new admissions to the facility, the facility failed to assess client B's functional ability related to her physical skills, physical dexterity, muscle dexterity, and for client B's quad(four footed) cane use. Findings include: On 3/24/14 from 6:10am until 7:55am at the group home, on 3/24/14 from 8:45am until 10:25am at the workshop, and on 3/24/14 from 3:35pm until 5:30pm, client B was observed to use a quad cane when she walked. During observation periods client B walked with a side to side, unsteady gait and used her quad cane for balance while walking and changing walking surfaces. A review of client B's record was conducted on 3/25/14 at 1:45pm. Client B's 4/1/2013 ISP (Individual Support Plan) indicated client B used a quad cane to walk and prevent falls. Client B was admitted to the facility on 4/8/2013. Client B's record did not indicate Physical Therapy or a Occupational Therapy assessments. Client B's 3/1/14	W000218	**W218 Individual Program Plan** This item outlines that the agency failed to assess Client B's functional ability related to her physical skills, physical dexterity, muscle dexterity and for Client B's quad cane use. The plan of correction for this tag is as follows: · For Client B, the nurse reports that the physician indicated that an OT/PT evaluation was not necessary. Carey Services utilizes the "Certification by Physician for Long-Term Care Services and Physical Examination for PASARR Level II; State Form 450B" for all residential annual physicals. The physician did document on the Annual Physical dated 04/11/2013 that "No Referral or Special Examinations are Required". Carey Services will update the Appointment Form to specifically add OT/PT/ST/Other as options for the physician to indicate if further assessment is necessary. The form will be updated by 4/25/2014. · For Client B, the physician has since ordered an OT/PT evaluation. This is scheduled for 4/18/2014 at 1:30PM at Marion General Hospital. · No other resident has been identified of having the potential to be affected by the same deficient practice.	04/25/2014

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	Physician's Order indicated an order for her to use a quad cane. Client B's diagnosis included, but was not limited to, Osteoarthritis. Client B's 4/13 "Fall Risk Management Plan" completed by the agency LPN (Licensed Practical Nurse) indicated client B had the "potential for injury related to risk factors: takes medication such as hypnotic, antipsychotic, antidepressant, antianxiety, narcotic...Cognitive Impairment, Uses assistive device...Unsteady gait or balance, muscular weakness particularly of the lower extremities...Begin regular exercise program: exercises that improve balance and coordination are the most helpful...Ambulatory devices used: Cane...." Client B's record did not indicate client B's functional ability related to client B's physical skills, physical dexterity, muscle dexterity, and for client B's quad cane use since admission. On 3/25/14 at 2:00pm, an interview was conducted with the agency's LPN. The LPN indicated she did believe client B had a PT or a OT assessment of client B's functional ability related to client B's physical skills, physical dexterity, muscle dexterity, and for client B's quad cane use upon admission or since admission to the facility. The LPN stated client B was "at			

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	risk for falls because [client B] used a cane" to walk. On 3/26/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional), the RM (Residential Manager), and the LPN was conducted. The three administrative staff indicated client B was admitted on 4/8/2013 and did not have PT or OT assessments for client B's functional ability related to client B's physical skills, physical dexterity, muscle dexterity, and for client B's quad cane use. The three (3) administrative staff indicated client B was at risk for falls and had poor balance while walking. The QIDP indicated client B had a standard cane upon admission and the facility obtained a quad cane after client B continued to have balance problems. The LPN stated client B's physician did not order a PT or a OT assessment upon admission. The QIDP and the LPN both stated client B's "Physician said it (the PT/OT assessments) were not needed." Both staff indicated no documented reason for not completing PT and OT assessments was available from client B's physician. The LPN indicated knowledge of client B's medical history was limited. 9-3-4(a)			

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W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients B and C) and 3 additional clients (clients D, E, and F) who lived in the group home, the facility failed to develop a plan which included how and when clients B, C, D, E, and F were to access the secured key for locked sharps or to access locked sharps. Findings include: On 3/24/14 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 03/01/2013 through 03/24/2014 and indicated the following incident for client A. -A 3/28/13 BDDS report for an incident on 3/27/13 at 8:40pm, indicated client A "came out of [client A's bed] room, went to the kitchen and pulled a butcher knife out of the drawer. [Client A] then started walking towards the hallway and looking for staff [a former staff #11]. [Former staff #12] came out of the med (medication) room and asked [client A] what he was doing. [Client A] stated he	W000240	**W240 Individual Program Plan** This item outlines that the agency failed to develop a plan which included how and when clients B, C, D, E and F were to access the secured key for locked sharps or to access locked sharps. The plan of correction for this tag is as follows: · For all clients, guardians and HRC will approve the safety protocol to have sharps locked up and the staff will have the key by 4/25/2014. The QDDP will facilitate this. See applicable consent form. · QDDP will update all applicable ISPs to reflect protocol of sharps safety information in the applicable behavioral section by 4/25/2014. · QDDP will write a goal for the applicable clients to access the sharps and to safely use sharp items. Goal will be written by 4/25/2014. · QDDP will add a line item in the Comprehensive Assessment tool (completed annually) that will assess whether or not the client is able to use a key. This addition will occur by 4/25/2014. · QDDP will add a goal for any client who cannot use a key to allow for that client to work on improving key use and turning skill. Assessments on this specific skill will occur by 4/25/2014 and then on each consumer's annual schedule	04/25/2014

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	was looking for [Former staff #11] because he had been telling [The QIDP (Qualified Intellectual Disabilities Professional)] lies. [Client A] paced up and down the hallway 3-4 times and then went back to dining room where [Former staff #12] asked [client A] to put the knife down and [client A] did. [Client A] then stated he wanted to kill himself and (he) wasn't homicidal." The report indicated the staff contacted the local police to transport client A to the behavioral hospital and he was admitted. On 3/24/14 from 6:10am until 7:55am at the group home and on 3/24/14 from 2:25pm until 5:30pm, a locked box was on the kitchen cabinet. At 2:25pm, GHS (Group Home Staff) #5 showed the locked box and indicated sharp objects such as knives, scissors, and other sharp objects were kept locked. GHS #5 removed the medication room keys from her pocket and opened the box. GHS #5 indicated the sharp objects were kept locked because of client A's aggressive behaviors. GHS #5 indicated clients B, C, D, E, and F did not have the need for the sharps to be kept locked. GHS #5 indicated clients B, C, D, E, and F would have to have a staff open the box to obtain a sharp knife. At 4:10pm, GHS #5 used a key from the ring of keys in her pocket to open and access the locked box		thereafter.	

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	and removed a sharp knife. At 4:10pm, clients A, B, C, D, and F indicated they did not have a key to the locked sharps box and had to ask staff each time they wanted scissors or to use a sharp knife. Client A's record was reviewed on 3/25/14 at 10:45am. Client A's 3/4/13 ISP (Individual Support Plan) and client A's 4/2013 BSP (Behavior Support Plan) both indicated targeted behaviors of Anger Outbursts which included Suicidal Ideation, verbal aggression, physical aggression, and non compliance. Client A's BSP indicated he had a history of talking about suicide and planning his suicide. Client A's record indicated he was admitted to the facility on 3/11/13. Client A's diagnoses included, but were not limited to, Mild Level of Intellectual Disability, Major Depression, PTSD (Post Traumatic Stress Disorder), Anxiety Disorder, and Borderline Personality Disorder. Client A's record indicated at the age of ten (10) years old client A had suffered a closed head injury when he was hit by a car and was in a coma for six weeks. Client A's 4/2013 BSP indicated "Suicidal Ideation...Sharp knives are to be locked and inaccessible to [client A]." Client A's record did not indicate how/when client A would access the keys to and/or locked sharp objects at the group home.			

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(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
	A review of client B's record was conducted on 3/25/14 at 1:45pm. Client B's 4/1/2013 ISP (Individual Support Plan) and 6/2013 BSP both did not have an assessment to access the key for locked items or to access locked sharp objects. Client B's plans did not indicate how/when client B would access the secured key and/or locked sharps. A review of client C's record was conducted on 3/25/14 at 12:35pm. Client C's 10/16/13 ISP (Individual Support Plan) did not have an assessment to access the key for locked items or to access locked sharp objects. Client C's record did not indicate how/when client C would access the secured key and/or locked sharps. On 3/26/14 at 10:00 AM, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Residential Manager (RM) was conducted. The QIDP and the RM indicated client A should have sharps locked and the key for locked sharps secured. The QIDP and RM both indicated clients B, C, D, E, and F did not have the identified need for the locked sharps or the secured key. The QIDP indicated the key had to be secured from client A's access to prevent his access to knives and sharp objects			

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	because of his identified behavioral needs. The QIDP indicated clients B, C, D, E, and F did not have a plan to indicate how or when clients B, C, D, E, and F would access the key for locked items or the locked items. 9-3-4(a)			

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W000249	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, for 2 of 3 sampled clients (clients B and C) and for 1 additional client (client D), the facility failed to teach clients B, C, and D about their medications when opportunities existed. Findings include: 1. On 3/24/14 at 6:30am, client D entered the medication room with Group Home Staff (GHS) #1. GHS #1 selected client D's medication cards, compared each card to client D's 3/2014 MAR (Medication Administration Record), and punched out each of client D's oral medications into a medication cup without naming the medication, the doses, side effects, or reasons for each medication. Client D's oral medications were Fish Oil 1000mg (milligrams) for Hyperlipidemia, Pot CL Micro (Potassium) 20meq/milliequivalents for supplement, Oyster Shell CA (calcium) for nutritional health, Oxybutynin 5mg (milligrams) for urinary incontinence,	W000249	**W249 Program Implementation** This item outlines that the agency failed to teach clients B, C and D about their medications when opportunities existed. The plan of correction for this tag is as follows: · Retraining has occurred with the applicable staff by the manager. This specific employee will have 4 successfully completed supervised medication passes before the employee is able to administer medications. · The manager will complete the 4 successful supervised medication passes to assure the employee is able to pass the medication in a manner that allows for teaching the clients about their medications. This will be completed by 4/25/2014. · The manager will complete weekly observations for 2 months and will adjust frequency based on the observations to assure the employee utilizes opportunities to teach the clients about his/her medications. · The manager will retrain all staff at the home on how to use informal and formal opportunities to teach clients	04/25/2014

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	Metformin 500mg for diabetes mellitus, Loratadine 10mg for allergies, Fluoxetine 40mg for depression, Fluoxetine 20mg for depression, Aricept 5mg for memory, Divalproex 500mg for behaviors, Bromcriptin (Bromocriptine) 2.5mg for Hyperlactenemia (Hyperprolactinemia), and Aspirin 81mg for diabetes mellitus. GHS #1 administered client D's liquid medications of Chlohex Solution (for periodontal disease and gum health), Omeprazl (Omeprazole) 20mg for stomach acid, and Deep Sea mist spray for allergies. No teaching was provided to client D of the names, doses, side effects, or reasons for the medications. On 3/24/14 at 10:30am, client D's 3/2014 MAR and 3/1/14 "Physician's Order" both indicated Fish Oil 1000mg (milligrams) for Hyperlipidemia, Pot CL Micro 20meq for supplement, Oyster Shell CA (calcium) for nutritional health, Oxybutynin 5mg (milligrams) for urinary incontinence, Metformin 500mg for diabetes mellitus, Loratadine 10mg for allergies, Fluoxetine 40mg for depression, Fluoxetine 20mg for depression, Aricept 5mg for memory, Divalproex 500mg for behaviors, Bromcriptin (Bromocriptine) 2.5mg for Hyperlactenemia (Hyperprolactinemia), and Aspirin 81mg for diabetes mellitus, Chlohex Solution (for periodontal disease		about his/her medications. The training will occur no later than 4/25/2014. · The QDDP will add a goal to dispense medication accurately per physician's order. These goals will be added no later than 4/25/2014. Staff will be trained on these goals also before 4/25/2014. · For Client B, the physician ordered a spacer for the inhaler which will enable the client to have visual confirmation when the inhaler is depressed. This will allow for the consumer to administer the inhaler puff more accurately. The spacer was received on 3/24/2014 and is currently in use.	

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	and gum health), Omeprazl (Omeprazole) 20mg for stomach acid, and Deep Sea mist spray for allergies. 2. On 3/24/14 at 6:50am, client C entered the medication room with GHS #1. GHS #1 selected client C's medication cards, compared each card to client C's 3/2014 MAR, and punched out each of client C's oral medications into a medication cup without naming the medication, the doses, side effects, or reasons for each medication. Client C's medications were "Deep Sea Mist 0.65% (for allergies), Hydrochlorot 12.5mg (for Hypertension), Lisinopril 10mg (for Hypertension), (and) Metoprolol 100mg (for Hypertension)." No teaching was provided to client C of the names, doses, side effects, or reasons for the medications. On 3/24/14 at 10:30am, client C's 3/2014 MAR and 3/1/14 "Physician's Order" both indicated "Deep Sea Mist 0.65% (for allergies), Hydrochlorot 12.5mg (for Hypertension), Lisinopril 10mg (for Hypertension), (and) Metoprolol 100mg (for Hypertension)." 3. On 3/24/14 at 7:15am, GHS #1 selected, client B's Proair HFA AER (aerosol inhaler) for shortness of breath, GHS #1 removed the inhaler from the			

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	bag, GHS #1 handed client B the inhaler, and GHS #1 did not instruct client B in inhaler usage. Client B held the inhaler, opened the inhaler cap, and administered four (4) pumps from the inhaler into her mouth without redirection. At 7:19am, GHS #1 indicated client B administered four (4) puffs from the inhaler into client B's mouth. GHS #1 stated client B "does not always feel it (the medication) hit the back of her mouth" so client B kept pumping the medication. GHS #1 did not provide teaching to client B of the name, dose, side effects, or reasons for the inhaler medication. On 3/24/14 at 10:30am, client B's 3/2014 MAR (Medication Administration Record) indicated "Proair HFA AER (aerosol inhaler), inhale 2 puffs orally four times daily as needed for Wheezing or shortness of breath." On 3/24/14 at 10:30am, client B's 3/1/2014 "Physician's Order" indicated "Proair HFA AER (aerosol inhaler), inhale 2 puffs orally four times daily as needed for Wheezing or shortness of breath." On 3/25/14 at 2:00pm, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated the agency staff followed the			

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	"Living in the Community: Core A/Core B" medication training. The LPN indicated clients B, C, and D should have been taught about each medication administered by the facility staff. On 3/25/14 at 2:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Residential Manager (RM) was conducted. The QIDP and the RM both indicated clients B, C, and D had medication goals to be implemented during their medication administration. The QIDP indicated the facility staff should have used formal and informal opportunities to have identified the name, dose, side effects, and reasons for each medication regardless of the specific medication goal. 9-3-4(a)			

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W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview for 2 of 37 doses of medications administered during medication administration (clients B and D), the facility failed to administer medications without error for clients B and D. Findings include: 1. On 3/24/14 at 6:30am, Group Home Staff (GHS) #1 selected, client D's Deep Sea Saline Mist 0.65% (for Allergies), held the open bottle to each of client D's nostrils, and administered 2 sprays in each nostril. At 6:45am, GHS #1 indicated she had administered 2 sprays into each of client D's nostrils. On 3/24/14 at 10:30am, client D's 3/2014 MAR (Medication Administration Record) indicated "Deep Sea Spr (spray) 0.65%, 1 spray in each nostril twice daily" for allergic rhinitis (allergies). On 3/24/14 at 10:30am, client D's 3/1/2014 "Physician's Order" indicated "Deep Sea Spr (spray) 0.65%, 1 spray in each nostril twice daily" for allergic	W000369	**W369 Drug Administration** This item outlines that the agency failed to administer medication without error. The plan of correction for this tag is as follows: · Retraining has occurred with the applicable staff by the manager. This specific employee will have 4 successfully completed supervised medication passes before the employee is able to administer medications. · The manager will complete the 4 successful supervised medication passes to assure the employee is able to pass the medication in a manner that allows for teaching the clients about their medications. This will be completed by 4/25/2014. · After the successful completion of the previous step, the manager will complete weekly observations for 2 months and will adjust frequency based on the observations to assure the employee is administering medication without error. · The QDDP will add a goal to dispense medication accurately per physician's order. These goals will be added no later than 4/25/2014. Staff will be trained on these goals also before 4/25/2014. · For Client B, the physician ordered a spacer for	04/25/2014

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	rhinitis (allergies). 2. On 3/24/14 at 7:15am, GHS #1 selected, client B's Proair HFA AER (aerosol inhaler) for shortness of breath, GHS #1 removed the inhaler from the bag, GHS #1 handed client B the inhaler, and GHS #1 did not instruct client B in inhaler use. Client B held the inhaler, opened the inhaler cap, and administered four (4) pumps from the inhaler into her mouth without redirection. At 7:19am, GHS #1 indicated client B administered four (4) puffs from the inhaler into client B's mouth. GHS #1 stated client B "does not always feel it (the medication) hit the back of her mouth" so client B kept pumping the medication. On 3/24/14 at 10:30am, client B's 3/2014 MAR (Medication Administration Record) indicated "Proair HFA AER (aerosol inhaler), inhale 2 puffs orally four times daily as needed for Wheezing or shortness of breath." On 3/24/14 at 10:30am, client B's 3/1/2014 "Physician's Order" indicated "Proair HFA AER (aerosol inhaler), inhale 2 puffs orally four times daily as needed for Wheezing or shortness of breath." On 3/25/14 at 2:00pm, an interview with		the inhaler which will enable the client to have visual confirmation when the inhaler is depressed. This will allow for the consumer to administer the inhaler puff more accurately. The spacer was received on 3/24/2014 and is currently in use.	

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	the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The LPN stated "All" medications label instructions and physician's orders should be followed. The LPN indicated client B and D's medications should have been administered according the the pharmacy label and each client's physician order. The LPN indicated the facility staff errored when the label and the physician's order were not followed. On 3/25/14 at 2:00pm, a review of the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician's orders. On 3/24/14 at 8:30am, a record review was completed of the facility's 11/20/2013 policy and procedures, "Medication Administration" which indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home. 9-3-6(a)			

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W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 3 sampled clients (client C) and 1 additional client (client D) with adaptive equipment, the facility failed to encourage the use of client C and D's prescribed eyeglasses when opportunities existed. Findings include: On 3/24/14 from 6:10am until 7:55am, clients C and D were observed at the group home to feed themselves breakfast, complete medication administration, and watch television. From 6:10am until 7:55am, clients C and D did not wear their prescribed eyeglasses and were not prompted or encouraged to wear their prescribed eyeglasses. On 3/24/14 from 8:45am until 10:25am, clients C and D were observed at the facility owned day services and did not wear their prescribed eyeglasses. From 8:45am until 10:25am, clients C and D bent at the waist over their individual items to color pictures outside the lines	W000436	**W436 Space and Equipment** This item outlines that the agency failed to encourage the use of Client C and D's prescribed eyeglasses when opportunities existed. The plan of correction for this tag is as follows: · Retraining will occur with all applicable staff to assure that all residents who have prescribed eyeglasses have the opportunity to wear then with meals and activities such as crafts by the manager. The monitoring agent will be a flow sheet. The flow sheet and the applicable staff training on the flow sheet will occur no later than 4/25/2014. · For clients who have instruction to wear prescription eyeglasses to prevent falls will be encouraged by staff to wear their eyeglasses at all times while ambulating. This will be captured on a flow sheet to indicate when the consumer was wearing the glasses and if they consumer is not wearing glasses; the form will capture the reason why the consumer is not wearing the glasses (such as refusals, etc.). The form and the applicable staff training on the form will occur no	04/25/2014

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	on paper, put puzzles together feeling with their fingers, and client D operated a paper shredder by feeling the shredder opening with her fingers. On 3/24/14 from 3:35pm until 5:30pm, clients C and D were observed at the group home. From 3:35pm until 4:15pm, client C did not wear his prescribed eyeglasses. At 4:15pm, GHS #6 prompted client C to obtain his eyeglasses and client C went into the medication room. Client C came out of the medication room wearing his eyeglasses, stood upright to walk, and sat straight in a chair at the table to complete a craft activity. From 3:35pm until 5:30pm, client D did not wear her prescribed eyeglasses and was not prompted or encouraged to wear her prescribed eyeglasses. On 3/25/14 at 12:35pm, client C's record was reviewed. Client C's 10/16/13 ISP (Individual Support Plan) indicated a goal/objective to wear his glasses daily for 1 hour with staff supervision. Client C's 3/14/14 Physician's History and Physical assessment indicated he wore prescribed eyeglasses. On 3/25/14 at 1:30pm, client D's 11/22/13 ISP indicated she wore prescribed eyeglasses and included a goal		later than 4/25/2014 by the manager. · The manager is responsible for monitoring that staff is completing all applicable paperwork accurately and correctly. If the staff fails to document as required on the form, progressive disciplinary action will occur up to and including termination of employment.	

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	for her to wear her eyeglasses. Client D's 10/2013 "Fall Risk" assessment completed by the Nurse indicated client D had vision problems and needed to wear her eyeglasses to prevent falls. On 3/25/14 at 2:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Residential Manager (RM) was conducted. The QIDP and the RM both indicated clients C and D wore prescribed eyeglasses to see. The QIDP indicated client C and D's goals were in place to teach clients C and D to wear their prescribed eyeglasses and should have been implemented during formal and informal opportunities. The RM indicated client D's eyeglasses were kept in an accessible drawer in the medication office. On 3/26/14 at 10am, an interview with the QIDP, RM, and the agency LPN (Licensed Practical Nurse) was conducted. The three administrative staff indicated clients C and D should have been prompted and encouraged by the group home staff to wear their prescribed eyeglasses during formal and informal opportunities. 9-3-7(a)			