

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(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	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: March 6, 7, 8, 11, 12, 18, 19, and 22, 2013.</p> <p>Facility number: 000833 Provider number: 15G314 AIM number: 100243960</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 28, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000	Intial Comments Section				

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
---	--

(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
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (client #1) and for 2 additional clients (clients #5 and #7), the facility failed to allow clients to have the right to access their locked bedroom thermostat controls.</p> <p>Findings include:</p> <p>During observation on 3/6/13 from 4:10pm until 6:51pm, clients #1, #5, and #7's bedroom thermostats were covered with a key locked hard plastic security cover. At 5:50pm, the Residential Manager (RM) indicated client #1, #5, and #7's bedroom temperature controls were not to be locked when interviewed. At 5:50pm, clients #1, #5, and #7 indicated they did not have a key to their locked bedroom thermostats.</p> <p>Client #1's record was reviewed on 3/11/13 at 10:00am, and on 3/18/13 at 12:17pm. Client #1's record and 3/15/12 ISP (Individual Support Plan) did not indicate client #1 needed to have her bedroom air temperature control locked.</p>	W000125	<p><b>W125 Protection of Clients Rights</b></p> <p>This item outlines that the agency failed to allow clients to have access to thermostat controls in their respective bedrooms. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will ensure the rights of all clients by allowing and encouraging each person to exercise his/her rights as clients and as citizens of the USA. These rights include the right to file complaints and the right to due process.</li> <li>· Specifically for clients #1, 5 and 7, the facility will allow clients to have the right to access their thermostat controls.</li> <li>· Lock boxes were removed on 03/6/2013.</li> <li>· Staff Training will be held on 04/11/2013 regarding client rights and not to have locks on thermostats without the consumer being assessed and</li> </ul>	04/11/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Clients #5 and #7's records were reviewed on 3/8/13 at 10:15am, and did not indicate the need for their bedroom air temperature control to be locked.</p> <p>On 3/8/13 at 10:15am, an interview was conducted with the QDP (Qualified Disabilities Professional). The QDP indicated client #1, #5, and #7's bedroom air temperature controls should not have been locked.</p> <p>9-3-2(a)</p>		<p>showing a need to have a lock in place and is subject to HRC approval. Staff will also be informed that for any consumer that displays no need for the lock on the thermostat, that consumer will be shown where to access the appropriate key to unlock any covers that in place.</p> <p>·Please find supplemental documentation for the training to come including: In-service /Staff Training Verification form, Pre and Post Test on the above topic area, Agency Policy on Consumer Rights and Consumer Appeal Process and Agency Policy on Abuse, Neglect and Exploitation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(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	
W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview and record review for 2 of 4 sampled clients (clients #3 and #4), the facility failed to ensure their right of access to their eye glasses.</p> <p>Findings include:</p> <p>During morning observations on 3/7/13 from 5:45am until 7:45am, client #3 and #4's prescribed eye glasses were kept inside the locked medication room. At 7:45am, clients #3 and #4's prescribed eye glasses were inside a basket which sat on the shelf inside the locked medication room.</p> <p>Client #3's record was reviewed on 3/11/13 at 9:40am, and on 3/18/13 at 10:00am. Client #3's 3/15/12 ISP (Individual Support Plan) did not indicate client #3 had been assessed in regard to the need to lock her personal eye glasses. Client #3's 3/15/12 ISP indicated she had eye glasses prescribed on 9/23/11 and had a goal/objective to wear her eye glasses daily for sixty (60) minutes. Client #3's 3/15/12 ISP and record indicated she had</p>	W000137	<p><b>W137 Protection of Clients Rights</b></p> <p>This item outlines that the agency failed to ensure client access to their eye glasses. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>·The facility will ensure that all clients have the right to retain and use appropriate personal possessions and clothing.</li> <li>·Specifically for client #3 and #4, the facility will allow the clients to have access to their eye glasses. Eye glasses will be located in an area that is not locked, allowing for unrestricted client access.</li> <li>·Staff Training will be held on 04/11/2013 regarding client rights as related to use and access to personal possessions and clothing. Staff will be informed that for any consumer that displays and assessed need for limited access to personal possession and/or clothing will have a plan signed consent and</li> </ul>	04/11/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>an advocate but did not indicate the client and/or her advocate had given written informed consent for limited access.</p> <p>Client #4's record was reviewed on 3/11/13 at 9:30am, and on 3/18/13 at 12:02pm. Client #4's 3/15/12 ISP did not indicate client #4 had been assessed in regard to the need to lock his eye glasses. Client #4's ISP indicated he had a goal/objective to wear his eye glasses daily for forty-five (45) minutes with supervision. Client #4's 3/15/12 ISP and record indicated he had an advocate and did not indicate the client and/or his advocate had given written informed consent to limited access.</p> <p>Interview with the Qualified Disabilities Professional (QDP) was conducted on 3/8/13 at 9:30am. The QDP indicated client #3 and #4's prescribed eye glasses were kept inside the medication room in a basket on the shelf. The QDP indicated the medication room door should not have been locked. The QDP indicated clients #3 and #4 should have been prompted to go into the medication room and obtain their prescribed eye glasses.</p> <p>9-3-2(a)</p>		<p>HRC approval for the restricted access if applicable.</p> <p>·Please find supplemental documentation for the training to come including: In-service /Staff Training Verification form, Pre and Post Test on the above topic area, Agency Policy on Consumer Rights and Consumer Appeal Process and Agency Policy on Abuse, Neglect and Exploitation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(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	
W000149	<p>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 interview and record review for 2 of 2 allegations of substantiated staff to client abuse for clients #3 and #6, the facility neglected to implement its Abuse/Neglect policy to report and thoroughly investigate allegations of abuse/neglect/mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law.</p> <p>Findings include:</p> <p>On 3/6/13 at 12:55pm, the facility's BDDS reports from 5/2/2012 through 3/6/2013 were reviewed and indicated the following substantiated staff to client allegations of abuse.</p> <p>For client #3. -A 7/29/12 BDDS report for an incident on 7/27/12 at 5:45pm, indicated "It was reported to [the QDP (Qualified Disabilities Professional)] that on 7/27/12 at approximately 5:45pm, [client #3] had requested additional food at dinner and that [discharged staff #1 and discharged staff #2] had mixed up together tuna, peaches, cheese, and other items on [client #3's] plate for her to eat. It was</p>	W000149	<p><b>W149 Staff Treatment of Clients</b></p> <p>This item outlines that the agency did not implement its Abuse/Neglect policy to report abuse/neglect/mistreatment to the administrator and to BDDS. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will ensure the development and implementation of written policies and procedures that prohibit abuse, neglect and/or mistreatment of clients.</li> <li>· Staff Training will be held on 04/11/2013 regarding: <ul style="list-style-type: none"> <li>o Policy 5.13 Abuse, Neglect and Exploitation</li> <li>o Policy 5.13.1 Elder Justice Act</li> <li>o Procedure 5.13.1 Procedures for Reporting Abuse and Neglect and Other Reportable or Unusual Incidents</li> <li>o Policy 5.8 Consumer Rights and Consumer Appeal Process</li> </ul> </li> </ul>	04/11/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>also reported that while [client #3] was consuming the food mixture that [discharged staff #2] video tape [client #3] (sic) on [discharged staff #2's] cell phone. This information was reported by staff and a consumer." The report indicated discharged staff #1 and discharged staff #2 were suspended pending an investigation.</p> <p>-A 10/13/12 follow up BDDS report indicated that discharged staff #2 denied that client #3 was video taped and denied mixing up client #3's food. The report indicated other staff interviewed indicated "they did watch a video on [discharged staff #2's] cell phone of [client #3] eating the food mixture." The report indicated discharged staff #2 was terminated on 8/6/12.</p> <p>For client #6.</p> <p>-A 8/2/12 BDDS report for an incident on 7/31/12 at 2:30pm, indicated that "during an interview with group home staff that [discharged staff #1] and [discharged staff #2] was witnessed to taunt and tease [client #6] causing him to get upset. This was to have occurred on more than one occasion between 7/7/12 and 7/26/12. [Residential Manager (RM)] was present on one occasion when this occurred, it was reported that [the RM] was laughing but when another staff commented that it</p>		<ul style="list-style-type: none"> <li>· Staff training will highlight the importance of notifying the Administrator immediately of any allegations of abuse, neglect, mistreatment and/or other reportable incidents so that a BDDS Incident Report can be submitting within the allotted time frame.</li> <li>· Please find supplemental documentation for the training to come including: In-service /Staff Training Verification form, Pre and Post Test on the above topic area, Agency Policy on Consumer Rights and Consumer Appeal Process and Agency Policy on Abuse, Neglect and Exploitation.</li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was upsetting [client #6] then [the RM] stopped laughing and started talking to [client #6] to calm him." The report indicated staff were suspended pending an investigation.</p> <p>-A 10/13/12 follow up BDDS report indicated the allegation was "substantiated" and the Discharged Staff #1 and Discharged Staff #2 were the two employees who were discharged on 8/6/12.</p> <p>On 3/6/13 at 12:55pm, a review of the investigations for client #3 and #6's allegations did not indicate why other facility staff did not immediately report the allegation to the Administrator and in accordance with State Law.</p> <p>The facility's records were reviewed on 03/6/13 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,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>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))."</p> <p>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 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."</p> <p>On 03/6/13 at 12:55pm, an interview with the QDP (Qualified Disabilities Professional) was conducted. The QDP indicated client #3 and #6's allegations were substantiated abuse by the facility staff. The QDP indicated the facility staff who witnessed the events and saw the evidence on the cell phone of teasing and taunting clients #3 and #6 did not</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>immediately report either allegation for client #3 or for client #6.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(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			
W000153	<p>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 interview and record review for 2 of 2 allegations of substantiated staff to client abuse for clients #3 and #6, the facility failed to immediately report allegations of abuse/neglect/mistreatment immediately to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law.</p> <p>Findings include:</p> <p>On 3/6/13 at 12:55pm, the facility's BDDS reports from 5/2/2012 through 3/6/2013 were reviewed and indicated the following substantiated staff to client allegations of abuse.</p> <p>For client #3. -A 7/29/12 BDDS report for an incident on 7/27/12 at 5:45pm, indicated "It was reported to [the QDP (Qualified Disabilities Professional) on 7/29/12] that on 7/27/12 at approximately 5:45pm, [client #3] had requested additional food at dinner and that [discharged staff #1 and discharged staff #2] had mixed up</p>	W000153	<p><b>W153 Staff Treatment of Clients</b></p> <p>This item outlines that the agency failed to ensure that 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. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will ensure that 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.</li> <li>· Staff Training will be held on 04/11/2013 regarding: <ul style="list-style-type: none"> <li>o Policy 5.13 Abuse, Neglect and Exploitation</li> </ul> </li> </ul>	04/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>together tuna, peaches, cheese, and other items on [client #3's] plate for her to eat. It was also reported that while [client #3] was consuming the food mixture that [discharged staff #2] video tape [client #3] (sic) on [discharged staff #2's] cell phone. This information was reported by staff and a consumer." The report indicated discharged staff #1 and discharged staff #2 were suspended pending an investigation.</p> <p>For client #6. -A 8/2/12 BDDS report for an incident on 7/31/12 at 2:30pm, indicated that "during an interview with group home staff that [discharged staff #1] and [discharged staff #2] was witnessed to taunt and tease [client #6] causing him to get upset. This was to have occurred on more than one occasion between 7/7/12 and 7/26/12. [Residential Manager (RM)] was present on one occasion when this occurred, it was reported that [the RM] was laughing but when another staff commented that it was upsetting [client #6] then [the RM] stopped laughing and started talking to [client #6] to calm him."</p> <p>-A 10/13/12 follow up BDDS report indicated the allegation was "substantiated" and the employees were discharged on 8/6/12.</p>		<ul style="list-style-type: none"> <li>o Policy 5.13.1 Elder Justice Act</li> <li>o Procedure 5.13.1 Procedures for Reporting Abuse and Neglect and Other Reportable or Unusual Incidents</li> <li>o Policy 5.8 Consumer Rights and Consumer Appeal Process <ul style="list-style-type: none"> <li>· Staff training will highlight the importance of notifying the Administrator immediately of any allegations of abuse, neglect, mistreatment and/or other reportable incidents so that a BDDS Incident Report can be submitting within the allotted time frame.</li> <li>· Please find supplemental documentation for the training to come including: In-service /Staff Training Verification form, Pre and Post Test on the above topic area, Agency Policy on Consumer Rights and Consumer Appeal Process and Agency Policy on Abuse, Neglect and Exploitation.</li> </ul> </li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/6/13 at 12:55pm, a review of the investigations for client #3 and #6's allegations did not indicate why other facility staff did not immediately report allegation to the Administrator and in accordance with State Law.</p> <p>On 03/6/13 at 12:55pm, an interview with the QDP (Qualified Disabilities Professional) was conducted. The QDP indicated client #3 and #6's allegations were substantiated abuse by the facility staff. The QDP indicated the facility staff who witnessed the events and/or saw the video on the cell phone did not immediately report either allegation for client #3 or for client #6. The QDP indicated client #3's allegation was reported when the agency was investigating a different incident.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(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			
W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, for 3 of 3 sample clients (clients #1, #2, and #3) who had physical interventions employed for behavior, the facility failed to have a written description in client #1, #2, and #3's plan for CPI (Crisis Prevention Intervention - a type of physical restraint intervention) which were used for behaviors.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 3/11/13 at 10:00am, and on 3/18/13 at 12:17pm. Client #1's 4/20/12 BSP (Behavior Support Plan) indicated the target behavior of "Physical Aggression is the intentional act or attempt to cause bodily harm to self, others, or inanimate/property destruction...Examples of aggression are, hitting, kicking, punching, biting, scratching, shoving, throwing objects, grabbing objects...." Client #1's BSP indicated "Reactive Measures...If [client #1] continues to be aggressive and is putting herself or others in harm staff will</p>	W000289	<p><b>W289 Management of Inappropriate Client Behavior</b></p> <p>This item outlines that the facility failed to have a written description in the clients' plan for CPI (Crisis Prevention Intervention – a type of physical restraint intervention) which were used for behaviors. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>The facility will ensure written descriptions in the clients' plan for CPI (Crisis Prevention Intervention – a type of physical restraint intervention) which is used for behaviors</li> <li>Specifically, for clients #1, #2 and #3 the Behavior Support Plans have been resubmitted for approval by the consumer, advocate, healthcare representative, guardian and with the Human Rights Committee with the addition of the po9licy 4.4.1 and a copy of the CPI team</li> </ul>	04/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>utilize the Team Control Position, Team Transport Position, or Emergency Floor Procedure as taught by Carey Services trainers. Nonviolent Physical Crisis Intervention is a safe, non harmful control and restraint technique used to control an individual until she can regain control of her behaviors. Refer to attachment titled Carey Services, Inc. Agency Policies and Procedures Policy number 4.4.1...." Client #1's record did not include explanations of the restraint procedures for staff access. Client #1's programs contained no behavior technique hierarchy for staff to employ for behavior management.</p> <p>2. Client #2's record was reviewed on 3/11/13 at 9:10am. Client #2's 7/2012 BSP (Behavior Support Plan) indicated client #2 had the target behavior of "Physical Aggression is the intentional act or attempt to cause bodily harm to self, others, or inanimate/property destruction...Examples of aggression are, hitting, kicking, punching, biting, scratching, hair pulling, and spitting...throwing objects, breaking glasses...." Client #2's target behaviors indicated verbal aggression and AWOL (Absent Without Leave) behaviors. Client #2's BSP indicated "If [client #2] escalates and is hitting inappropriate objects to the extent of serious injury</p>		<p>control position and CPI interim control position.</p> <ul style="list-style-type: none"> <li>Staff Training will be held on 04/11/2013 on Behavior Support Plans and CPI responses.</li> <li>Please find supplemental documentation for the Behavior Support Plans, Approvals and CPI documentation as described above.</li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and/or hitting other people, staff will utilize the Team Control Position as taught by Carey Services trainers. Non violent Physical Crisis Intervention is a safe, non harmful control and restraint techniques used to control an individual until she can regain control of her behaviors. Refer to attachment titled Carey Services, Inc. Agency Policies and Procedures Policy number 4.4.1." Client #2's BSP indicated if client #2 left the facility AWOL the staff should follow her, encourage client #2 to return, and if client #2 did not return and was unsafe staff should "If physical assistance is necessary, utilize the Team Control Position" referring to the policy #4.4.1. Client #2's record did not define the restraints for staff access. Client #2's programs contained no behavior technique hierarchy for staff to employ for behavior management.</p> <p>3. Client #3's record was reviewed on 3/11/13 at 9:40am, and on 3/18/13 at 10:00am. Client #3's 7/2012 BSP (Behavior Support Plan) indicated client #3 had the target behaviors of Aggression defined as "Physical Aggression is the intentional act or attempt to cause bodily harm to self, others, or inanimate/property destruction...Examples of aggression are, hitting, kicking, punching, biting, scratching, hair pulling, shoving,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>pinching, and suicide attempts." Client #3's BSP indicated client #3 picked scabs or sores on her body and banged her head during behaviors. Client #3's BSP indicated "Reactive Strategies...If [client #3] is not calming down, redirections are not working, and she is in danger of hurting herself or others, staff will utilize the Team Control Position as taught by Carey Services trainers. Non violent Physical Crisis Intervention is a safe, non harmful control and restraint techniques used to control an individual until she can regain control of her behaviors. Refer to attachment titled Carey Services, Inc. Agency Policies and Procedures Policy number 4.4.1." Client #3's record did not define holds used for client #3. Client #3's programs contained no behavior technique hierarchy for staff to employ for behavior management.</p> <p>On 3/8/13 at 10:15am, the facility's 6/15/2011 "#4.4.1: Behavior Modification and Training policy" was reviewed with the QDP (Qualified Disabilities Professional). The policy indicated "C. Level Three Interventions include: 2. Physical Restraint: is defined as one or more persons physically limiting another's movements of body or limbs through hands on physical contact." The policy indicated CPI physical restraint interventions for CPI Interim Control</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Position, CPI Team Control Position, CPI Transport Position, CPI Applied Physical Training/Emergency Floor Procedure, and Four Person Physical Restraint. The QDP indicated CPI was used for client #1, #2, and #3's behaviors and were not clearly explained/defined in their written plans but should have been.</p> <p>9-3-5(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(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			
W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to ensure nursing assessments of clients' health status were completed on a quarterly basis.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/11/13 at 10am, and on 3/18/13 at 12:17pm. Client #1's record indicated "Nursing Quarterly" assessments completed on 2/13/13, 9/3/12, 6/13/12, and 3/26/12. No nursing quarterly assessment was done for the 4th quarter of 2012 (October, November, December).</p> <p>Client #2's record was reviewed on 3/11/13 at 9:10am. Client #2's record indicated "Nursing Quarterly" assessments completed on 2/12/13, 9/3/12, 6/13/12, and 3/26/12. No nursing quarterly assessment was done for the 4th quarter of 2012 (October, November, December).</p> <p>Client #3's record was reviewed on</p>	W000336	<p><b>W336 Nursing Services</b></p> <p>This item outlines that the facility failed to ensure nursing assessments of clients' health status were completed on quarterly basis. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will ensure nursing assessments are completed on a quarterly basis.</li> <li>· The Group Home Nurse has a schedule for completion of this task. She will be held accountable to this schedule by the Chief Programs Officer and the Director of Group Homes during regularly scheduled meeting established to ensure all requirements are completed in a timely fashion.</li> </ul>	04/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3/11/13 at 9:40am and on 3/18/13 at 10:00am. Client #3's record indicated "Nursing Quarterly" assessments completed on 2/13/13, 9/3/12, and 3/26/12. No nursing quarterly assessments were done for the 2nd quarter of 2012 (April, May, and June) and for the 4th quarter of 2012 (October, November, December).</p> <p>Client #4's record was reviewed on 3/11/13 at 9:30am and on 3/18/13 at 12:02pm. Client #4's record indicated "Nursing Quarterly" assessments completed on 2/13/13, 9/3/12, 6/13/12, and 3/26/12. No nursing quarterly assessment was done for the 4th quarter of 2012 (October, November, December).</p> <p>On 3/11/13 at 10am and on 3/22/13 at 3pm interviews with the QDP (Qualified Disabilities Professional) and the agency LPN (Licensed Practical Nurse) were conducted. Both the QDP and the LPN indicated no additional nursing quarterly assessments for clients #1, #2, #3, and #4 were available.</p> <p>9-3-6(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(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			
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview for 4 of 4 sample clients (clients #1, #2, #3, and #4) and 1 additional client (client #7) living in the group home, the facility failed to administer medications without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>On 3/6/13 at 12:55pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/12 through 3/6/13 were reviewed and indicated the following for client #1, #2, #3, #4, and #7's medication errors.</p> <p>For client #1. -A 2/7/13 BDDS report for an incident on 2/6/13 at 7:00am, indicated facility "staff contacted [the agency] nurse at 7:30pm on 2/6/13 to question physician's orders. Client had an order listed for Seasonale Tab as well as Seasonique Tab. Client received both birth control tabs on 2/1, 2/2, 2/4, 2/5, and 2/6/2013." The report indicated client #1's "Seasonale Tab" was discontinued.</p> <p>-A 11/1/2012 BDDS report for an</p>	W000368	<p><b>W368 Drug Administration</b></p> <p>This item outlines that the facility failed to administer medication without error and as prescribed by the clients' personal physician. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will assure that all drugs are administered in compliance with the physician's orders.</li> <li>· Staff Training will be held on 04/11/2013 on Policy 7.12 Medication, Procedure 7.12.3 Medication Administration by Staff and to review that food must be offered for specific medications per the MAR and must align with that consumer's specific dietary requirements.</li> <li>· The Group Home Nurse will complete observations of medication passes two times per month to assure that the employees are following all applicable policies and procedures as applicable to ensure that all drugs are administered in compliance with physician's orders.</li> </ul>	04/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>incident on 11/1/12 at 7:00am, indicated client #1 "did not receive her 7am Calcium+D 500-200" medication (for nutrition). The report indicated client #1's medication was ordered, "but order in MAR (Medication Administration Record) for Nov. (11/2012) was for Chewable Calcium Carb D 500-400. Pharmacy stated that order was received in Oct. from PCP (Doctor)."</p> <p>-A 7/29/12 BDDS report for an incident on 7/28/12 at 5:00pm, indicated client #2 received client #1's medications of "Pramipexole 0.25mg (milligrams) (antidyskinetic), Trazodone 50mg (for behaviors), and Oyster Shell Calcium 500mg (for nutrition)" and client #1 did not receive her 5:00pm medications. The report indicated client #1 received her unlisted 7:00pm and 9:00pm medications before 7:30pm on 7/28/12.</p> <p>For client #2.</p> <p>-A 12/31/12 BDDS report for an incident on 12/30/12 at 7:00am, indicated "staff reported on 12/31/12 at 8:30am, that there was no Levora (for birth control) in the house and med. (medication)" had been omitted.</p> <p>-A 12/18/12 BDDS report indicated on 12/18/12 at 7:00am, client #2 received "2 100mg/milligrams Clozaril (for</p>		<ul style="list-style-type: none"> <li>· The Upland Group Home Manager will complete observation of medication passes 2 times per week to assure that the employees are following all applicable policies and procedures as applicable to ensure that all drugs are administered in compliance with physician's orders.</li> <li>· The other Home Managers will complete med pass observations at this home once per quarter to assure that the employees are following all applicable policies and procedures as applicable to ensure that all drugs are administered in compliance with physician's orders.</li> <li>· Please find supplemental documentation to include copies of the aforementioned policy and procedure as well as the In-Service/Staff Training Verification form</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>behaviors) and current order is Clozaril 100mg 1 cap daily."</p> <p>-A 7/29/12 BDDS report for an incident on 7/28/12 at 5pm, indicated client #2 received her (client #2's) 5pm, 7pm, and 9:00pm, Calcium 500mg (for nutrition), Xanax 0.25mg (for behaviors), Lovaza 1gm/gram (2 tabs) (for lowering triglycerides), Divalproex 500mg (for seizures), Clonazepam 200mg (for behaviors), Benztropine 0.5mg (for side effects of medications), Vitamin E (for nutrition), and Poly Powder (for constipation) all at the 5:00pm medication administration. Client #2 also received client #1's medications as well of "Pramipexole 0.25mg (antidyskinetic), Trazodone 50mg (for behaviors), and Oyster Shell Calcium 500mg (for nutrition)." The report indicated client #2 had "increase in drowsiness."</p> <p>-A 7/29/12 BDDS report for an incident on 7/27/12 at 7:00am, indicated client #2 "did not receive her 7am dose of Xanax 0.25mg (for behaviors)" medication.</p> <p>-A 6/11/12 BDDS report for an incident on 6/11/12 at 7:40am, indicated "nurse was notified at 7:43am that [client #2] took another clients' medications. Medications included "Dok Sod. (Colace) 100mg (for constipation), Fish Oil 2000mg (for nutrition), Invega 3mg (for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>behaviors), Loratadine 10mg (for allergies), Lybrel 90-20mcg (for birth control), Oyst. (Oyster) Shell/D 500mg (for nutrition), Prampexole 0.25mg (for shaking/tremors), Singulair Chew 5mg (for allergies), and Divalproex 500mg (for seizures).</p> <p>For client #3.</p> <p>-A 8/17/12 BDDS report for an incident on 8/16/12 at 12:00pm, indicated client #3 was given 1 Bromocriptine 5mg (for Hyperlaclenemia secretions). But should have received 3 tablets to equal 15mg.</p> <p>-A 5/4/12 BDDS report for an incident on 5/2/12 at 7:00am, indicated client #3 was to receive Singulair 10mg (for allergies) "every morning" at 7:00am and it was discontinued on 3/20/12. Client #3's medication was delivered by pharmacy and staff administered the medication on 5/1 and 5/2/12.</p> <p>-A 6/4/12 BDDS report for an incident on 6/4/12 no time documented, indicated client #3 "staff accidentally gave extra dose of Levothyroxine 50mcg (for low thyroid activity) after she had already received it."</p> <p>For client #4.</p> <p>-A 10/16/12 BDDS report for an incident on 10/16/12 at 8:00pm, indicated client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#4 was given client #5's medications after the staff had set up client #5's medications of Docusate Sodium (for constipation) and Ranitidine 150mg (for allergies).</p> <p>-A 5/19/12 BDDS report for an incident on 5/18/12 at 7:00am, indicated staff "omitted" client #4's medications at 7am of "Levothyroxine 50mcg, Lisinopril 10mg, Hydrochlorthiazide 12.5mg (for high blood pressure), and Metoprolol ER 100mg (for high blood pressure)."</p> <p>For client #7.</p> <p>-A 9/11/12 BDDS report for an incident on 9/11/12 at 7:00am, indicated client #7's Lasix 20mg (for water retention) 1/2 tab "QOD (every other day)" and staff gave "medication on 9/10 (9/10/12)." The report indicated client #7's Lasix will be held on 9/13/12.</p> <p>Client #1's record was reviewed on 3/11/13 at 10:00am and on 3/18/13 at 12:17pm. Client #1's 3/1/13 "Physician's Order" indicated the medications of Seasonique Tab, Calcium+D 500-200, Pramipexole 0.25mg (milligrams), and Trazodone 50mg.</p> <p>Client #2's record was reviewed on 3/11/13 at 9:10am. Client #2's 3/1/13 "Physician's Order" indicated "Calcium Carb +D (plus vitamin D) 500-400 chew,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>give 1 tab by mouth twice daily with food, Levora 28 tab (birth control) 1 tablet by mouth daily, Clozaril 100mg 1 cap daily, Xanax 0.25mg (for behaviors), Lovaza 1gm (2 tabs) (for lowering triglycerides), Divalproex 500mg (for bi-polar disorder), Clonazepam 200mg give 1 tab by mouth every night at bedtime for schizophrenia, Benztropine 0.5mg give 1 tablet by mouth 2 times daily, Vitamin E give give 1 capsule by mouth 3 times daily, and Poly Powder dissolve 1 capful 17gm (grams) in 8oz. (ounces) Liquid twice daily."</p> <p>Client #3's record was reviewed on 3/11/13 at 9:40am, and on 3/18/13 at 10am. Client #3's 3/1/13 "Physician's Order" indicated "Bromocriptin tab 2.5mg, give 6 capsules (15mg) by mouth 3 times daily with food for Hyperlaclenemia, Fish Oil 1,000mg capsule give 1 capsule orally three times a day with meals, Claritin 10mg (Singulair 10mg) give 1 tab by mouth every morning, and Levothyroxine 50mcg give 1 tab by mouth every morning before meal for Hypothyroidism.</p> <p>Client #4's record was reviewed on 3/11/13 at 9:30am and on 3/18/13 at 12:02pm. Client #4's 3/1/13 "Physician's Order" indicated "Levothyroxine 50mcg give 1 tablet by mouth daily, Lisinopril</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>10mg give 1 tablet by mouth daily, Hydrochlorthiazide 12.5mg give 1 capsule by mouth daily, and Metoprolol ER 100mg give 2 tabs (200mg) by mouth daily."</p> <p>Client #7's record was reviewed on 3/8/13 at 9:10am. Client #7's 3/1/13 "Physician's Order" did not indicate an order for "Lasix" medication.</p> <p>On 3/8/13 at 9:30am, a record review was completed of the facility's policy and procedures, 11/07 "Medication Administration by Staff" indicated "1. Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...5. Check the medication listed on the medication administration record with the medication label three times...Administration of oral medication. All medication that specifies administration with food should be given within 1/2 hr [hour] of food consumption...." The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 3/8/13 at 9:30am, the 2004 "Core A/Core B Medication Training" indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>On 3/8/13 at 9:20am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders but should have.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(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	
W000369	<p><b>483.460(k)(2)</b> <b>DRUG ADMINISTRATION</b> The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 9 of 13 medications administered during the evening medication administration (for clients #2, #3, and #7), the facility failed to ensure medications were given without error.</p> <p>Findings include:</p> <p>1. On 3/6/13 at 5:07pm, Direct Care Staff (DCS) #1 requested client #2 to come to the medication room, DCS #1 unlocked the medication cart, retrieved client #2's medication card of "Calcium Carb +D (plus vitamin D) 500-400 chew (for bone health), give 1 tab by mouth twice daily with food," compared the medication card to the MAR (Medication Administration Record), dated 3/2013, and DCS #1 punched the medication into a souffle cup. DCS #1 administered the medication to client #2, client #2 took the medication with water, and no food was observed provided. At 6:46pm, client #2 consumed her first bite of supper and DCS #1 indicated no food/meal had been provided before 6:46pm.</p> <p>Client #2's record was reviewed on</p>	W000369	<p><b>W369 Drug Administration</b> This item outlines that the facility failed to ensure medications were given without error. The plan of correction for this tag is as follows: · The facility will ensure that medications are given without error. · Food will be offered as ordered by a physician as indicated in the Medication Administration Record. · The food that is offered will comply with each specific and applicable consumer's dietary orders. · Staff Training will be held on 04/11/2013 on Policy 7.12 Medication, Procedure 7.12.3 Medication Administration by Staff and to review that food must be offered for specific medications per the MAR and must align with that consumer's specific dietary requirements. · The Group Home Nurse will complete observations of medication passes two times per month to assure that the employees are following all applicable policies and procedures as applicable to ensure that all drugs are administered in compliance with physician's orders. · The Upland Group Home Manager will complete observation of medication passes 2 times per</p>	04/11/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>3/11/13 at 9:10am. Client #2's 3/1/13 "Physician's Order" indicated "Calcium Carb +D (plus vitamin D) 500-400 chew, give 1 tab by mouth twice daily with food."</p> <p>2. On 3/6/13 at 5:15pm, Direct Care Staff (DCS) #1 requested client #3 to come to the medication room, DCS #1 unlocked the medication cart, retrieved client #3's medication card of "Bromocriptine tab 2.5mg (milligrams), give 6 capsules (15mg) by mouth 3 times daily with food for Hyperlaclenemia. Fish Oil 1,000mg [for skin turgor] give 1 capsule orally three times a day with meals," compared the medication card to the 3/2013 MAR (Medication Administration Record), and punched the medication into a souffle cup. DCS #1 administered the medication to client #3, client #3 took the medication with water, and no food was observed provided. At 6:46pm, client #3 consumed her first bite of supper and DCS #1 indicated no food/meal had been provided before 6:46pm.</p> <p>Client #3's record was reviewed on 3/11/13 at 9:40am, and on 3/18/13 at 10:00am. Client #3's 3/1/13 "Physician's Order" indicated "Bromocriptine tab 2.5mg, give 6 capsules (15mg) by mouth 3 times daily with food for Hyperlaclenemia. Fish Oil 1,000mg</p>		<p>week to assure that the employees are following all applicable policies and procedures as applicable to ensure that all drugs are administered in compliance with physician's orders. · The other Home Managers will complete med pass observations at this home once per quarter to assure that the employees are following all applicable policies and procedures as applicable to ensure that all drugs are administered in compliance with physician's orders. · Please find supplemental documentation to include copies of the aforementioned policy and procedure as well as the In-Service/Staff Training Verification form</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>capsule give 1 capsule orally three times a day with meals."</p> <p>3. On 3/6/13 at 5:25pm, Direct Care Staff (DCS) #1 requested client #7 to come to the medication room, DCS #1 unlocked the medication cart, retrieved client #7's medication card of "Calcium Carb +D (plus vitamin D) 600-200 chew (for bone health), give 1 tab by mouth twice daily with food." DCS #1 compared the medication card to client #7's 3/2013 MAR (Medication Administration Record), punched the medication into a souffle cup, administered the medication to client #7, client #7 took the medication with water, and no food was observed provided. At 6:46pm, client #7 consumed her first bite of supper and DCS #1 indicated no food/meal had been provided before 6:46pm.</p> <p>Client #7's record was reviewed on 3/8/13 at 9:10am. Client #7's 3/1/13 "Physician's Order" indicated "Calcium Carb +D (plus vitamin D) 600-200 chew, give 1 tab by mouth twice daily with food."</p> <p>On 3/8/13 at 9:30am, an administrative record review was completed of the facility's policy and procedures, "Medication Administration by Staff," dated 11/07, and included "1. Check the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.				STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...5. Check the medication listed on the medication administration record with the medication label three times...Administration of oral medication. All medication that specifies administration with food should be given within 1/2 hr [hour] of food consumption...."</p> <p>An interview with the agency's LPN (License Practical Nurse) was conducted on 3/8/13 at 9:30am. The agency LPN indicated a medication ordered "with meal" should be taken no more than 30 minutes before a meal. The agency LPN indicated facility staff should have followed client #2, #3, and #7's physician orders to administer their medications.</p> <p>On 3/8/13 at 9:30am, 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 orders.</p> <p>9-3-6(a)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2013

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
(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	