

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 04/28/2015
--	---	--	---

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
W 000 Bldg. 00	<p>This visit was for the pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 4/21, 4/22, 4/23, 4/24, and 4/28/15.</p> <p>Facility Number: 000833 Provider Number: 15G314 AIM Number: 100243960</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation, record review and interview, for 1 of 4 sampled clients (client #1), the facility failed to encourage and teach personal privacy during medication administration when opportunities existed.</p> <p>Findings include:</p> <p>On 4/21/15 from 3:50pm until 6:35pm, and on 4/22/15 from 6:15am until</p>	W 130	<p>W130 Protection of Clients Rights This item outlines that the agency failed to encourage and teach personal privacy during medication administration when opportunities existed. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·All applicable staff will receive retraining on policy to assure personal privacy when opportunities exist on or before 5/28/2015. ·The consumer will be educated at each medication pass on the opportunity for personal 	05/28/2015

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 04/28/2015
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>8:25am, client #1 was at the group home. On 4/21/15 at 5:50pm, the medication room door was open to view into the kitchen where clients #2, #3, #4, #5, and #7 were watching and preparing supper. On 4/21/15 at 5:50pm, client #1 with GHS (Group Home Staff) #1 drew 16 units of insulin into a syringe, pulled up his shirt and lowered his pants, the medication room door was open, and client #1 injected the insulin syringe into his Left lower side. At 5:50pm, client #1 was in full view of the kitchen when he injected the syringe. On 4/22/15 at 6:50am, client #1 stood inside the medication doorway and tested his blood sugar in full view of the kitchen and dining room where clients #2, #4, and #5 assembled their breakfast. GHS #2 drew client #1's insulin inside the medication room with client #1 in full view of the kitchen and dining room, and client #1 injected the insulin syringe into his exposed abdomen on the right side. The medication room door was open to the kitchen and dining room with clients #2, #4 and #5 watching client #1 inside the medication room doorway. No privacy was taught or encouraged by GHS #1.</p> <p>On 4/22/15 at 10:40am, an interview was conducted with the CCO (Chief Compliance Officer). The CCO indicated the facility followed Core</p>		<p>privacy and his rights. ·The home manager will assure compliance during routine medication observations. The manager will explicitly monitor the insulin at 2 out of 3 applicable medication passes X 1 week. The manager, if observations confirm compliance, can reduce frequency of confirmation to 1 out of 3 applicable medication passes X 1 week. Ongoing monitoring will occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. Confirmation will occur by Director of Group Homes/QDDP and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</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 04/28/2015
--	---	--	---

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
W 249 Bldg. 00	<p>A/Core B Living in the Community Medication Administration policy and procedure for medication administration.</p> <p>On 4/23/15 at 8:10am, an interview with the COO (Chief Operating Officer) was conducted. The COO indicated client #1 should have been redirected to close the door to the medication room during formal and informal opportunities to teach and encourage personal privacy during medication administration.</p> <p>On 4/23/15 at 10:00am, the 2002 Living in the Community Medication Administration Core A/Core B policy and procedure was reviewed. The policy and procedure indicated client medications should be given in a private area.</p> <p>On 4/21/15 at 2:05pm, the agency's 2/19/15 "Consumer Rights and Consumer Appeal Process" policy and procedure indicated "...6. Consumers shall have the opportunity for personal privacy...."</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/28/2015	
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>each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview, and record review, for 2 of 4 sampled clients (clients #3 and #4) who needed secured sharps for safety, the facility failed to ensure clients #3 and #4's BSPs (Behavior Support Plans) were implemented to secure locked sharps when not in direct staff supervision for clients #3 and #4.</p> <p>Findings include:</p> <p>On 4/21/15 from 4:50pm until 6:35pm and on 4/22/15 from 6:15am until 8:25am, observations were conducted at the group home. During both observation periods, clients #3 and #4 were in the kitchen of the facility and selected utensils from the kitchen drawers. During both observation periods, the kitchen drawer with large utensils had two (2) metal pizza cutters with metal blades stored inside the drawer. During both observation periods, two (2) metal thermometers, each having eight (8) inch long metal tips with sharp ends, were stored inside the kitchen silverware drawer and accessed by clients #3 and #4.</p>	W 249	<p>W249 Program Implementation</p> <p>This item outlines that the agency failed to ensure BSPs were implemented to secure locked sharps when not in direct staff supervision for applicable clients. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> · The pizza cutters and metal thermometers were secured prior to exit of this survey. · All applicable staff will receive training on BSPs and securing all sharps on or before 5/28/2015. · The home manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. Confirmation will occur by Director of Group Homes/QDDP and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. · Staff training will occur to assure all staff is knowledgeable that knives and sharps are not to be restricted. This will occur no later than 5/28/2015. 	05/28/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2015
--	---	---	---

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>At 7:30am, GHS (Group Home Staff) #2 and GHS #3 both indicated clients #3 and #4 had the identified need for locked sharp objects and for the sharps to be kept secured because of their behaviors and for the safety of other clients and staff. At 7:30am, GHS #2 and GHS #3 both indicated they did not consider metal pizza cutters and the two metal thermometers as sharps and stated "but they (the sharp objects) could be a weapon."</p> <p>Client #3's record was reviewed on 4/24/15 at 12:20pm. Client #3's 3/2015 ISP (Individual Support Plan) and 2/2014 BSP (Behavior Support Plan) both indicated client #3 had the identified need for locked sharps at the group home for safety. Client #3's 2/2014 BSP indicated client #3 had the targeted behaviors of physical aggression. Client #3's BSP indicated "All sharp objects and knives should be kept in a locked cabinet for [client #3's] safety and the safety of others in the home." Client #3's ISP indicated a goal/objective for client #3: "with complete safe handling of sharp instruments in the kitchen...Staff will supervise and give assistance as needed when [client #3] is handling sharp instruments in the kitchen. [Client #3] will obtain the key to the lock box, unlock the lock box, and retrieve a knife</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2015
--	---	---	---

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>suitable for intended purpose (sic)."</p> <p>Client #4's record was reviewed on 4/24/15 at 11:40am. Client #4's 3/13/15 ISP (Individual Support Plan) and 8/2014 BSP (Behavior Support Plan) indicated client #4 had the identified need for locked sharps at the group home for her safety and the safety of other people. Client #4's 8/2014 BSP indicated: "Because [client #4's] mood and thinking can change very quickly, it is important that knives and other sharp objects are in a locked cabinet. This is for [client #4's] safety and the safety of those around her."</p> <p>On 4/24/15 at 11:40am, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1 was conducted. QIDP #1 stated "sharps and knives" should be kept locked and secured at the group home because of clients #3 and #4's behaviors. QIDP #1 indicated clients #3 and #4 had the identified need for locked sharps and knives to protect the clients from harming themselves or others. QIDP #1 indicated metal thermometers and metal pizza cutters would be considered a sharp objects.</p> <p>9-3-4(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 04/28/2015
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	
W 331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 3 clients (client #2) who had medications administered during the evening medication administration, the facility's nursing staff failed to provide oversight to ensure client #2 had routine medications refilled by the pharmacy and to ensure client #2's physician's orders were followed.</p> <p>Findings include:</p> <p>On 4/21/15 at 5:06pm, GHS (Group Home Staff) #1 asked client #2 to come into the medication room, administered client #2's oral medications, and did not administer client #2's "Provigil 200mg (milligrams), give one tablet by mouth 2 times daily" (to promote wakefulness) medication, and/or client #2's "Welchol 625mg, give 3 tabs by mouth twice daily" (for Cholesterol) medication. GHS #1 stated the medications were "on hold" and had not been filled by the pharmacy. At 6:15pm, client #2's 4/2015 MAR (Medication Administration Record) indicated "Provigil 200mg (milligrams), give one tablet by mouth 2 times daily" since 2/28/2014 (to promote wakefulness) medication, and "Welchol 625mg, give 3 tabs by mouth twice daily"</p>	W 331	<p>W331 NursingServices</p> <p>This item outlines that the agency failed to provide oversight to ensure routine medications were refilled by the pharmacy and to ensure physician's orders were followed. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> The physician has reviewed the medication profile and the applicable required prior authorizations. The physician determined that the best course of action for the clients' applicable diagnoses and condition is to discontinue Welchol and Provigil; started on Statin. Documentation for CPAP machine use and client refusal (if this occurs) will be found CPAP flowsheet. Staff will have been trained on new procedure on or before 5/28/2015. The nurse will assure all orders are clearly indicated on physician orders and applicable MARs for staff's knowledge. The nurse, along with the home manager, will monitor all orders at least weekly to assure ongoing compliance. 	05/28/2015	

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 04/28/2015
--	---	--	---

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>since 11/24/2014 (for Cholesterol) medication had not been administered during the month of 4/2015 and the medications were "pending." At 5:06pm, client #2 was administered her Albuterol treatment for Asthma by nebulizer. Client #2 fell asleep continuously and had to be aroused by the facility staff during the treatment.</p> <p>Client #2's record was reviewed on 4/24/15 at 1:00pm. Client #2's 3/13/15 ISP (Individual Support Plan) did not indicate client #2 was non compliant with her medications. Client #2's 4/2015 and 1/14/15 Nursing Quarterly reviews indicated client was non compliant with CPAP (continuous positive airway pressure) machine and did not indicate the number of times client #2 had refused the machine. Client #2's 1/14/15 Nursing Quarterly review indicated "...New sleep study ordered to determine need and...set up. Will also look at resuming use of Provigil after study results" signed by the agency nurse.</p> <p>-Client #2's 4/1/2015, 3/2015, 2/2015, and 12/2014 "Physician's Orders" indicated "Provigil 200mg (milligrams), give one tablet by mouth 2 times daily" (to promote wakefulness) medication started 2/28/14, and "Welchol 625mg, give 3 tabs by mouth twice daily" (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 04/28/2015
--	---	--	---

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>Cholesterol) medication started 11/24/14.</p> <p>-Client #2's 1/28/15 Pulmonology Progress note indicated client #2 "is still having a lot of cough. She is on Advair 500 BID (twice daily). She is using the Albuterol nebulizer 4 times a day. Her [breathing test] score is 22 and she is breathing better than last time. She has been on Provigil for excessive daytime sleepiness...Her past (medical history) revealed pathologic hypersomnia and (she) was diagnosed with Narcolepsy (sleep disorder)....She had a...CPAP titration study in July (2014). She is using the CPAP but her sleep time and wake time varies night to night...."</p> <p>-Client #2's record indicated a 9/3/14 "Pulmonology Progress Note" from the physician which indicated "Visit Information...She has been having increased cough and SOB (Shortness of Breath) for a couple of months...She has been on Provigil for excessive daytime sleepiness...past (medical history) revealed pathologic hypersomnia and (she) was diagnosed with Narcolepsy (a sleep disorder) She had a repeat [name of test] two months ago...She then had a CPAP (sleep study for at night) titration study in July. She is still not on CPAP yet. The company has not set it up yet. It was ordered in July (2014)."</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 04/28/2015
--	---	--	---

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>-Client #2's Pulmonologist ordered "Provigil" medication on 1/28/15, 12/17/14, and 9/3/14. Client #2's record included 1/28/15, 12/17/14, and 9/3/14 Pulmonology Progress Notes which indicated the use of "Provigil 200mg" twice daily for "maintenance." Client #2's Pulmonology Progress Notes did not indicate client #2 was non-compliant with her medication.</p> <p>-Client #2's record included a 1/5/15 E-mail from the contracted pharmacist that indicated: "Just wanted to give a heads up regarding [client #2's] on the [Provigil medication]. We requested to obtain refills per attached document to a [name of Physician] and office called [name of pharmacy] and said that they are not going to grant refills due to non-compliance. This med will be placed on hold status and not sure how you want to handle this issue. But wanted to let you know that we did reach out to the MD for refills and this was response from MD office." A 1/6/15 at 10:33am, E-mail from the agency nurse to the group home manager indicated: "Please see (pharmacy's response for) [client #2's] (Provigil medication) will be on hold due to non-compliance with taking medications." Client #2's record included E-mail dated 12/29/14 at</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 04/28/2015
--	---	--	---

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>12:16pm, from the agency nurse which indicated "...I have attached notes from her most recent appointment with (the Pulmonologist) listing her current medication orders" and the nurse did not indicate the status of client #2's Provigil medication. An E-mail on 12/29/14 at 9:48am from the Residential Manager (RM) to the agency nurse indicated: "Wanted to let you know that for [client #2's], her [Provigil medication] is still pending refills from MD (Physician)...12/25/14 at 3:02am, (from the Group Home Staff) While going through cycle fill (from pharmacy) and checking for meds (medications) not sent. I noticed (the pharmacy) didn't send [client #2's] (Provigil 200mg), she's completely out as of now...." Client #2's record did not indicate why client #2's Welchol medication was not refilled when client #2 had a physician's order for the medication.</p> <p>On 4/22/15 at 11:20am, an interview with the CCO (Chief Compliance Officer) was conducted. Client #2's information regarding her Provigil and Welchol medications being on hold was requested and no information was available for review. An interview with the agency nurse was requested from the CCO. At 11:50am, no interview and no further information was available.</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 04/28/2015	
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 4/23/15 at 8:10am, an interview with the COO (Chief Operations Officer) was conducted. Client #2's information regarding her Provigil and Welchol medications being on hold was requested and no information was available for review. Nursing information was requested regarding client #2's on hold medications. At 12:40pm, no further information was available for review.</p> <p>On 4/24/15 at 10:50am, a record review was completed of the facility's policy and procedures, 9/17/14 "Medications" indicated the facility followed "Living in the Community" Core A/Core B medication administration. The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 4/24/15 at 10:50am, 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>On 4/24/15 at 11:40am, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1 was conducted. QIDP #1 indicated staff should administer medications according to physician's</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 04/28/2015	
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			
W 382 Bldg. 00	<p>orders. QIDP #1 indicated she would check on why client #2's Provigil and Welchol medications were on hold and not administered. QIDP #1 indicated she was unsure why the pharmacy would not refill client #2's medications. No further information was available for review.</p> <p>On 4/28/15 at 12:15pm, an interview with the COO (Chief Operations Officer) was conducted. The COO indicated client #2's Provigil and Welchol medications were ordered by client #2's physician and were not available for client #2's use at the group home and should have been.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, and #7's medications were kept secured when not being administered.</p>	W 382	<p>W382 DrugStorage and Recordkeeping This item outlines that the agency failed to ensure clients medications were kept secure when not being administered. The plan of correction for this tag is as follows: ·All applicable staff will be retrained on how to secure medications when not</p>	05/28/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/28/2015
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>Findings include:</p> <p>On 4/22/15 from 6:15am, GHS (Group Home Staff) #2 administered client #6's medications. At 6:20am, client #6 exited the medication room with GHS #2. GHS #2 left the eye sight of the medication room with the keys on top of the medication cart and the medication cart was unlocked. From 6:20am until 7:08am, GHS #2 administered client #4's medications. At 7:08am client #4 exited the medication room and GHS #2 left the medication keys on top of the locked medication cart. No staff were within eye sight of the medication cart. Clients #1, #2, #3, #4, #5, #6, and #7 walked throughout the group home and accessed each area of the home.</p> <p>On 4/24/15 at 11:40am, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1 was conducted. QIDP #1 indicated medications at the group home should be kept secured when not being administered. QIDP #1 indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 4/24/15 at 10:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in</p>		<p>beingadministered. The procedure is thatstaff is to keep medication keys in a secure location when not being used.</p> <p>The home managerwill assure compliance during routine medication observations. The manager will explicitly monitor the keysat 75% of applicable medication passes X 1 week. The manager, if observations confirmcompliance, can reduce frequency of confirmation to 50% of applicablemedication passes X 1 week. Ongoingmonitoring will occur each day that the manager is at the home. The frequency is generally 5 days out ofevery 7. Confirmation will occur byDirector of Group Homes/QDDP and Chief Operations Officer during home visits monthlyand quarterly respectively. All levelswill assure ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2015
--	---	---	---

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
W 383 Bldg. 00	<p>"Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>On 4/24/15 at 10:30am, the facility's 2/19/15 "Medication Control and Storage" policy indicated "...1. All medications administered by staff shall be stored under lock or attended by persons with authorized access...."</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility staff failed to ensure the medication keys for clients #1, #2, #3, #4, #5, #6, and #7's medications were kept secured.</p> <p>Findings include:</p> <p>On 4/22/15 from 6:15am, GHS (Group Home Staff) #2 administered client #6's medications. At 6:20am, client #6 exited</p>	W 383	<p>W383 DrugStorage and Recordkeeping This item outlines that the agency failed to ensure the medication keys were kept secured. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> All applicable staff will be retrained on how to secure medications when not being administered. The procedure is that staff is to keep medication keys in a secure location when not being used. The home manager will assure compliance during routine medication observations. The manager will explicitly monitor the 	05/28/2015

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 04/28/2015
--	---	--	---

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>the medication room with GHS #2. GHS #2 left the eye sight of the medication room with the keys on top of the medication cart and the medication cart unlocked. From 6:20am until 7:08am, GHS #2 administered client #4's medications. At 7:08am client #4 exited the medication room and GHS #2 left the medication keys on top of the medication cart. From 7:08am until 8:25am, the keys to the medication cart were left unsecured on top of the medication cart. No staff stayed within eye sight of the medication cart. Clients #1, #2, #3, #4, #5, #6, and #7 walked throughout the group home and accessed each area of the home.</p> <p>On 4/24/15 at 11:40am, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1 was conducted. QIDP #1 indicated the keys for the medication cart at the group home should be kept secured. QIDP #1 indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 4/24/15 at 10:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications</p>		<p>keysat 75% of applicable medication passes X 1 week. The manager, if observations confirm compliance, can reduce frequency of confirmation to 50% of applicable medication passes X 1 week. Ongoing monitoring will occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. Confirmation will occur by Director of Group Homes/QDDP and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</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 04/28/2015	
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			
W 436 Bldg. 00	<p>keys should be kept secured.</p> <p>On 4/24/15 at 10:30am, the facility's 2/19/15 "Medication Control and Storage" policy indicated "...1. All medications administered by staff shall be stored under lock or attended by persons with authorized access. Medication keys must be in constant possession of the individual responsible for the administration of medication. The keys shall be turned over to the next responsible individual at the end of the shift."</p> <p>9-3-6(a)</p> <p>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 2 of 4 sampled clients (clients #2 and #3) with adaptive equipment, the facility failed to teach and encourage client #2 to wear her prescribed eye glasses at the group home and for client #3 to wear her lower partial plate during meals.</p>	W 436	<p>W436 Spaceand Equipment This item outlines that the agency failed to teach and encourage client #2 (M.J.) to wear her prescribed eye glasses and for client #3 (B.C.) to wear her lower partial plate during meals. The plan of correction for this tag is as follows: ·Dining Recommendation: Staff will be trained, prior to 5/28/2015,</p>	05/28/2015			

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 04/28/2015
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>Findings include:</p> <p>1. On 4/21/15 from 4:50pm until 6:25pm, client #2 did not wear her prescribed eye glasses at the group home. During the observation period, client #2 watched television, looked at magazines, completed writing on a sheet of paper, walked throughout the group home, completed medication administration, consumed meals, assisted to prepare supper, and cleaned her bedroom. During the observation period, client #2 was not taught or encouraged to wear her prescribed eye glasses.</p> <p>On 4/24/15 at 1:00pm, client #2's record was reviewed. Client #2's 3/13/15 ISP (Individual Support Plan) indicated client #2 wore prescribed eye glasses and did not include a goal/objective to teach client #2 to wear her eye glasses at the group home. Client #2's ISP indicated client #2 "has prescription glasses but refuses to wear them stating it irritates the bridge of her nose. This has been reviewed by the team and has been determined to not be a risk."</p> <p>On 4/24/15 at 1:00pm, an interview was conducted with the Residential Manager (RM). The RM indicated client #2 did not wear her prescribed eye glasses because the frames were bent.</p>		<p>on updated dining plan to include encouragement to wearlower partial plate during meals.</p> <p>·Carey ServicesNurse to assure dining plan is updated via registered dietician review.</p> <p>·PrescribedGlasses: All clients that use prescribedglasses are potentially affected by this deficient practice. Staff to be trained on using formal andinformal opportunities to use glasses no later than 5/28/2015.</p> <p>·The home managerwill assure compliance during routine group home observations, to occur eachday that the manager is at the home. Thefrequency is generally 5 days out of every 7. Confirmation will occur by Director of Group Homes/QDDP and Chief OperationsOfficer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</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 04/28/2015
--	---	--	---

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
W 454	<p>2. On 4/21/15 from 4:50pm until 6:15pm, client #3 wore her partial dental plate. At 6:15pm, client #3 sat down at the dining room table for supper and had regular diet consistency food. At 6:15pm, client #3 took out her partial plate and put it aside. From 6:15pm until 6:25pm, client #3 consumed her regular consistency food at the table without staff redirecting or providing teaching to wear her partial lower plate to chew the food. At 6:25pm, client #3 indicated she was not wearing her lower dentures and wore her upper dentures. Client #3 fed herself 1 to 2, two inch sized, French Fries at a time before chewing the items.</p> <p>On 4/24/15 at 12:20pm, client #3's record was reviewed. Client #3's 9/19/13 Dental appointment indicated she was fitted with dentures for eating.</p> <p>On 4/24/15 at 11:40am, an interview was conducted with QIDP (Qualified Intellectual Disabilities Professional) #1. QIDP #1 indicated client #3 should have been taught and encouraged to wear her lower partials while eating.</p> <p>9-3-7(a)</p> <p>483.470(l)(1)</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 04/28/2015	
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			
Bldg. 00	<p>INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 3 additional clients (clients #5, #6, and #7), the facility failed to ensure the group home staff implemented sanitary methods for clients #1, #2, #3, #4, #5, #6, and #7's table knives and for client #2's nebulizer.</p> <p>Findings include:</p> <p>1. On 4/21/15 at 5:06pm, GHS (Group Home Staff) #1 retrieved client #2's assembled nebulizer mask from the shelf inside the medication room next to a used hair brush with loose hair and a staff's drinking cup. Client #2's nebulizer mask was stored assembled with moisture inside the chamber on the shelf, uncovered. At 5:06pm, GHS #1 emptied containers of Albuterol into the chamber and client #2 was administered her Albuterol treatment for Asthma by nebulizer. Client #2 fell asleep continuously and had to be aroused by the facility staff during the treatment.</p> <p>On 4/22/15 at 7:08am, GHS #2 retrieved client #2's assembled nebulizer mask from the shelf inside the medication</p>	W 454	<p>W454 InfectionControl This item outlines that the agency failed to ensure the group home staff implemented sanitary methods for clients' table knives and for client #2 (M.J.) nebulizer. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Nursing staff will develop protocol for sanitary cleansing and storage of nebulizer and assure all applicable items are in place to assure compliance. ·All staff will be trained on protocol for sanitary method to cleanse and store the nebulizer equipment. Additionally, all staff will be trained on sanitary methods in the kitchen and will include the expectation that eating utensils are not to be used as screwdrivers and if a utensil is used in any manner, that utensil is considered 'dirty' and will require sanitation before putting the utensil back into the clean utensil storage. ·The home manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. Confirmation will occur by Director of Group Homes/QDDP and Chief Operations Officer during home visits monthly and quarterly respectively. All levels 	05/28/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/28/2015
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>room next to a used hair brush with loose hair. Client #2's nebulizer mask was stored assembled and uncovered. GHS #2 selected client #2's Albuterol medication, poured the medication into the nebulizer, and administered the medication to client #2.</p> <p>Client #2's record was reviewed on 4/24/15 at 1:00pm. Client #2's 4/2015 Physician's Orders indicated "Albuterol" for Asthma four times a day by nebulizer mask.</p> <p>2. On 4/22/15 at 6:25am, GHS #2 selected a skillet from the kitchen cabinet and retrieved a table knife from the silverware drawer. GHS #2 used the table knife to tighten the screw to the handle of the skillet and replaced the same used knife back into the silverware drawer. From 6:45am until 8:25am, clients #1, #2, #3, #4, #5, #6, and #7 used the silverware from the silverware drawer to eat breakfast, butter their toast, butter their waffles, and spread their condiments on sandwiches to pack inside their lunch boxes.</p> <p>On 4/24/15 at 11:40am, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1 was conducted. QIDP #1 indicated the facility followed Universal Precautions taught during</p>		will assure ongoing compliance.		

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 04/28/2015
--	---	--	---

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>"Living in the Community" Core A/Core B Medication Administration and for care of medical equipment. QIDP #1 indicated client #2's nebulizer should have been cleaned when stored. QIDP #1 indicated staff should have used sanitary methods for the silverware. QIDP #1 indicated staff should have ensured the knife was washed before replacing the knife back into the silverware drawer.</p> <p>On 4/22/15 at 11:20am, the agency's policy and procedure for infection control, cleaning, and the storage of client #2's nebulizer was requested from the CCO (Chief Compliance Officer). On 4/23/15 at 8:10am, and on 4/24/15 at 10:50am, the agency's policy and procedure for infection control, cleaning, and the storage of client #2's nebulizer was requested from the COO (Chief Operations Officer). No policy regarding the cleaning and storage of client #2's nebulizer was made available for review.</p> <p>On 4/24/15 at 10:50am, the facility's 11/20/13 "Infection Control" policy indicated "Carey Services will provide a sanitary environment to avoid sources and transmission of infection."</p> <p>9-3-7(a)</p>			

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

PRINTED: 05/21/2015

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 <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/28/2015
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	