

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2015
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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348
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W 0000 Bldg. 00	<p>This visit was for an extended fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 4/20, 4/21, 4/22, 4/23, 4/24, and 4/28/2015.</p> <p>Facility number: 000644 Provider number: 15G107 AIM number: 100234170</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview, and record review, for 1 of 4 sampled clients (client #1), the governing body failed to develop and have available a policy and procedure for the care and maintenance of liquid oxygen and portable oxygen tanks at the facility for client #1.</p> <p>Findings include:</p>	W 0104	<p>W104 GoverningBody</p> <p>This item outlines that the agency failed to develop and have available a policy and procedure for the care and maintenance of liquid oxygen and portable oxygen tanks at the facility. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Policy and Procedure were developed and approved. ·Mandatory Training to occur with staff on the new policy and 	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.

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	<p>On 4/20/15 from 3:20pm until 6:30pm, client #1 was observed at the group home with GHS (Group Home Staff) #1 and GHS #2. From 3:20pm until 6:05pm, client #1 was inside her bedroom and an oxygen concentrator and a tank of liquid portable oxygen was beside her on the floor by the bed. Client #1 sat on her bed without wearing her oxygen cannula which administered her oxygen from the portable tank. At 5:30pm, client #1 indicated she had more than one liquid oxygen tank inside her bedroom and pointed to her closet. Inside client #1's closet were ten (10) liquid oxygen tanks, three (3) were empty, and seven (7) were full of liquid oxygen. Two (2) of the seven (7) full tanks of liquid oxygen were on their sides and rolled out when the closet door was opened. None of the ten (10) liquid oxygen tanks were anchored to secure the full tanks. At 5:30pm, GHS #1 indicated bedroom closet was not vented to the outside and not labeled as an oxygen storage area. GHS #1 indicated client #1's ten oxygen tanks were commingled among client #1's personal belongings and clothing within the unvented closet. GHS #1 indicated no policy or procedure was available for review at the group home for the care and maintenance of client #1's liquid oxygen tanks.</p>		<p>procedure no later than 5/28/2015. Included in the training will be the home manager, responsible for implementation of the policy and procedure and ongoing compliance.</p> <p>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 and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p>				

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	<p>On 4/21/15 from 6:55am until 8:30am, client #1 was observed at the group home. At 7:50am, GHS #6 opened client #1's closet and a liquid oxygen tank rolled out onto the bedroom floor from the closet. GHS #6 indicated there were ten (10) tanks of liquid oxygen commingled inside client #1's closet with her clothing and the tanks had clothing items stacked on top of some of the tanks. GHS #6 indicated the liquid portable oxygen tanks were not secured in place inside the closet. At 7:50am, GHS #6 and client #1 indicated client #1's liquid oxygen tanks were kept in the unvented closet inside client #1's bedroom.</p> <p>On 4/23/15 at 10:00am, client #1's record was reviewed. Client #1's 10/14/14 ISP (Individual Support Plan) indicated client #1 used liquid oxygen daily and used an oxygen concentrator at night. Client #1's 4/2015, 2/20/15, and 11/21/14 Physician's orders indicated "resume oxygen 1.5 (litters) at night and as needed to keep (oxygen saturations above) 90%."</p> <p>On 4/24/15 at 10:45am, on 4/28/15 at 12:15pm, and on 4/28/15 at 3:00pm, interviews were conducted with the COO (Chief Operations Officer). The COO indicated she was waiting for the nursing staff and the group home staff to provide</p>			

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W 0125 Bldg. 00	<p>the agency's policy and procedure for the care and maintenance of oxygen in the group home. No further information was available for review.</p> <p>9-3-1(a)</p> <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, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 1 additional client (client #5) who lived in the group home, the facility failed to ensure unimpeded access to knives and sharps for clients #1, #2, #3, #4, and #5, who did not have documented assessments for the restricted access to the secured items.</p> <p>Findings include:</p> <p>On 4/20/15 from 3:20pm until 6:30pm, clients #1, #2, #3, and #4 were at the group home with GHS (Group Home Staff) #1 and GHS #2. From 3:20pm until 6:05pm, clients #1, #2, #3, #4, and #5 did not have access to</p>	W 0125	<p>W125 Protection of Clients Rights</p> <p>This item outlines that the agency failed to ensure unimpeded access to knives and sharps for the clients. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·All clients were affected by this deficiency. ·Knives and sharps were unlocked and all clients had unrestricted access prior to exit of the survey. ·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 and Chief Operations Officer during 	05/28/2015

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	<p>locked knives and sharps. From 6:05pm until 6:30pm, client #2 set the table with GHS #1, for supper. At 6:15pm, clients #1, #2, #3, #4, and #5 sat down to eat their supper meal. At 6:15pm, GHS #1 cut and prepared client #2's meat custodially and clients #1, #2, #3, #4, and #5 were not provided a knife to use at the dining room table. At 5:05pm, GHS #1 and GHS #2 both indicated the group home kept knives and sharp items locked up because of a client who no longer lived at the group home. GHS #1 and GHS #2 both indicated the previous client was discharged in 2/2015 and the restriction continued.</p> <p>On 4/23/15 at 10:00am, client #1's record was reviewed. Client #1's 10/14/14 ISP (Individual Support Plan), 10/14/14 Essential Lifestyle plan, and 4/1/14 CFA (Comprehensive Function Assessment) did not indicate an identified need to secure sharps and knives. Client #1's record did not indicate consent for secured sharp items.</p> <p>On 4/23/15 at 10:30am, client #2's record was reviewed. Client #2's 10/14/14 ISP, 10/14/14 Essential Lifestyle plan, and 4/1/14 CFA (Comprehensive Function Assessment) did not indicate an identified need to secure sharps and</p>		<p>home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</p> <p>·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.</p>				

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	<p>knives. Client #2's record did not indicate consent for secured sharp items. Client #2's ISP indicated a goal/objective to safely use a knife during dining.</p> <p>On 4/23/15 at 9:00am, client #3's record was reviewed. Client #3's 3/27/15 ISP and 3/27/15 Essential Lifestyle plan did not indicate an identified need to secure sharps and knives. Client #3's record did not indicate consent for secured sharp items. Client #3 was admitted to the facility on 4/1/15 from a large private facility and no CFA was available for review.</p> <p>On 4/23/15 at 9:45am, client #4's record was reviewed. Client #4's 10/14/14 ISP, 10/14/14 Essential Lifestyle plan, and 4/1/14 CFA (Comprehensive Function Assessment) did not indicate an identified need to secure sharps and knives. Client #4's record did not indicate consent for secured sharp items. Client #4's ISP indicated a goal/objective to safely use a knife during dining.</p> <p>On 4/28/15 at 12:15pm, an interview was conducted with the COO (Chief Operations Officer). The COO indicated clients #1, #2, #3, #4, and #5 did not have the identified need for locked/secured sharps and knives. The COO indicated the restriction was for a client who was</p>			

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W 0137 Bldg. 00	<p>discharged in 2/2015 and the restriction was not changed for the group home after that client was discharged.</p> <p>9-3-2(a)</p> <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. Based on observation, interview, and record review, for 1 of 4 sampled clients (client #3), the facility failed to ensure client #3's clothing was in good repair.</p> <p>Findings include: On 4/20/15 from 3:20pm until 6:30pm, and on 4/21/15 from 6:55am until 8:30am, client #3 wore shirts with tears in the collar of the shirt and tears in the back of his shirts. During the 4/20/15 observation period, client #3's shirt had spots on the front between the neck collar and the waist of the shirt. Client #3 was not taught or encouraged to change his shirts. At 5:05pm, GHS (Group Home Staff) #2 indicated client #3's clothing had holes when he was admitted. GHS #2 indicated client #3's shirt and pants were not clean today.</p>	W 0137	<p>W137 Protection of Clients Rights This item outlines that the agency failed to assure that client #3 (A.L.) had clothing in good repair. The plan of correction for this tag is as follows: · Client #3 (A.L.) moved from a Large ICF/IDD to Carey Services on 4/1/2015. The clothing that he came with was not in good repair. Carey Services sought funding for this client to purchase new clothing. The clothing was purchased before the survey exited. · Carey Services has available funds and provided these resources for this purpose. The agency will continue to seek donations to assist people who do not have resources to meet basic needs. · The home manager will assure that all clients have clothing in good repair during routine</p>	05/28/2015

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W 0149 Bldg. 00	<p>On 4/23/15 at 9:00am, client #3's record was reviewed. Client #3's 3/27/15 ISP (Individual Support Plan) did not indicate a goal/objective for dressing and/or to wear clothing that was clean and in good repair.</p> <p>On 4/24/15 at 11:40am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) #1 was conducted. The QIDP #1 indicated client #3 was a new admission to the facility. QIDP #1 indicated client #3 should wear clean clothing daily.</p> <p>9-3-2(a)</p> <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 record review and interview, for 2 of 2 allegations reviewed (for clients #1, #2, #3, #4, and #5) and reported for 2 of 9 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility neglected to implement its Abuse, Neglect, and/or Mistreatment policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment for clients</p>	W 0149	<p>grouphome 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 and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</p> <p>W149 Staff Treatment of Clients This item outlines that the agency failed to implement its Abuse, Neglect, Mistreatment policy and procedure to immediately report allegations of staff abuse, neglect and/or mistreatment immediately to the administrator and to BDDS in accordance with state law. The plan of correction for this tag is as follows: · Group Home Manager will</p>	05/28/2015

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	<p>#1, #2, #3, #4, and #5 immediately to the administrator and to BDDS in accordance with state law and neglected to ensure staff were available and supervised clients at the group home.</p> <p>Findings include:</p> <p>On 4/21/15 at 2:10pm, the facility's BDDS reports were reviewed and indicated the following for allegations of abuse, neglect, and/or mistreatment:</p> <p>-An 4/17/15 BDDS report and an 4/14/15 investigation for an incident on 4/11/15 at 6:21pm indicated "Two staff reported to the [Name of Residential Manager (RM)] that on Saturday April 11, [client #4] was left in soiled and dirty depends (adult incontinency briefs) by day services staff and when transported to a Med Express (Doctor's Appointment) staff states she was found to have dried feces in the depends and on her leg and buttocks." The report and investigation indicated two staff reported their findings to the RM on 4/11/15. The report indicated the RM went into the group home on 4/12/15 to give the staff, involved in the incident on 4/11/15, written warnings regarding neglecting to provide services and support to client #4. The RM did not complete a report or initiate an investigation. The 4/17/15</p>		<p>receive disciplinary action and will complete mandatory training on the Investigation Process no later than 5/28/2015. The training will include, but is not limited in scope to the following:</p> <ul style="list-style-type: none"> ·Failure to suspend accused staff immediately pending an investigation ·Failure to initiate an investigation ·Failure to report to BDDS or Carey Services or COO for at least 3 days ·Failure to investigate the allegations before administering disciplinary action ·Failure to protect the integrity of the investigation initiated by the Corporate Compliance by reporting to one staff the specifics of the allegation when suspending her. ·Failure to protect the integrity of the investigation initiated by Corporate Compliance by allowing 2 staff to ride to the agency in a company vehicle while suspended. ·The policy and procedure of Abuse, Neglect, Mistreatment and Exploitation will be a standing agenda item at this home's monthly staff meeting to address what is reportable and the required timing of reporting these incidents. The manager will track all staff who attend these mandatory meetings and keep documentation in the manager's working files. The manager is 				

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	<p>BDDS report was completed by the Chief Compliance Officer (CCO) who reported the 4/11/15 incident on 4/14/15 and completed the investigation into the allegation. The CCO's investigation indicated the following: "The allegation of neglect was made to and acknowledged by the group home manager (RM) on Saturday and no immediate action was taken as required. Several required actions were disregarded by the group home manager (RM) and include...Failure to provide for the safety of the consumers by immediately suspending the staff accused of [the allegation] pending an investigation. Failure to initiate an investigation. Failure to report the [allegation] to BDDS or the Carey Services and/or COO for at least 3 days. Failure to investigate the allegations before administering disciplinary action against 2 accused staff. Failure to protect the integrity of the investigation initiated by the CCO (Chief Compliance Officer) by reporting to one of the staff the specifics of the allegation when suspending her. Failure to protect the integrity of the investigation initiated by the CCO by allowing the 2 accused staff to ride to the agency in a company vehicle while suspended." The report and investigation indicated the allegation was "Not Substantiated" because of the time frame</p>		<p>responsible for addressing any staff person who could not attend the mandatory meeting to assure he/she receives the information covered including this standing agenda item.</p> <ul style="list-style-type: none"> The manager will initiate interviews with all staff and will include direct questioning about observing any Abuse, Neglect, Mistreatment or Exploitation. The manager will meet with each staff person at least once per month to assure any issue was reported per policy, procedure and state law requires. These interviews will be documented on a form entitled "Reflection Session" and will be submitted to the Director of Group Homes or the Chief Operations Officer in the Director's absence. These interviews at this frequency will occur indefinitely. The Director of Group Homes and/or Chief Operations Officer will review all submitted documentation from the manager's interviews (staff and consumer interviews) as well as any documentation from Group Home Observation to identify any issues or concerns as related to the topics of reporting ANME or acts of ANME. 				

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	<p>to get from the group home to the medical appointment was in excess of 30 minutes and client #4 could have been incontinent, and client #4 was being seen for her incontinence issues.</p> <p>-4/1/15 BDDS report for an incident on 3/26/15 through 3/31/15 (no time given) and a 4/8/15 investigation indicated "Staff reported to the [Residential Manager name] that [GHS (Group Home Staff) #3] was asleep on the couch when they arrived and that is (sic) an ongoing occurrence." The 4/8/15 investigation indicated "There is a history of staff reporting to [RM] that they either suspect or have witnessed [GHS #3] asleep at morning shift change. Repeated attempts by managers to catch [GHS #3] asleep have failed to do so." The reports indicated staff changed their testimony and the home has "a history of conflict between staff members of different shifts, making it difficult to ascertain whether the reports are sincere." The reports indicated the allegation was "Not Substantiated" and "it is impossible to confirm that [GHS #3] was sleeping." The reports indicated the RM will conduct drop in visits to monitor the situation for the overnight shift of work.</p> <p>On 4/28/15 at 12:15pm, an interview with the COO was conducted. The COO</p>			

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	<p>indicated the two (2) allegations were not reported immediately to the administrator and to BDDS in accordance with state law. The COO indicated the facility staff neglected to follow the agency's policy and procedure to protect the clients from abuse, neglect, and/or mistreatment. The COO stated clients #1, #2, #3, #4, and #5 "required" twenty-four hour a day, seven days a week, staff supervision for eating, dressing, bathing, and active treatment. The COO indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations.</p> <p>On 4/21/15 at 8:35am, the facility's records were reviewed. A review of the facility's 6/15/11 policy on "Abuse, Neglect, and Exploitation" indicated, "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible abusive treatment, negligence, or exploitation on the part of staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency....Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and</p>			

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W 0153 Bldg. 00	<p>equipment (as indicated in the ISP (Individual Support Plan))."</p> <p>On 4/21/15 at 8:45am, 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's 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>9-3-2(a)</p> <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 record review and interview,</p>	W 0153	W153 StaffTreatment of	05/28/2015			

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	<p>for 2 of 2 allegations reviewed (for clients #1, #2, #3, #4, and #5), and for 2 of 9 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to immediately report allegations of staff to client abuse, neglect, and/or mistreatment for clients #1, #2, #3, #4, and #5 to the administrator and to BDDS in accordance with state law 460 IAC 9-3-1(b)(5).</p> <p>Findings include:</p> <p>On 4/21/15 at 2:10pm, the facility's BDDS reports were reviewed and indicated the following for allegations of abuse, and neglect, and/or mistreatment:</p> <p>-An 4/17/15 BDDS report and an 4/14/15 investigation for an incident on 4/11/15 6:21pm indicated "Two staff reported to the [Name of Residential Manager (RM)] that on Saturday April 11, [client #4] was left in soiled and dirty depends (adult incontinency briefs) by day services staff and when transported to a Med Express (Doctor's Appointment) staff states she was found to have dried feces in the depends and on her leg and buttocks." The report and investigation completed by the CCO (Chief Compliance Officer) indicated two staff reported their findings to the RM on 4/11/15. The investigation</p>		<p>Clients</p> <p>This item outlines that the agency failed to immediately report allegations of staff to client abuse, neglect and/or mistreatment. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Group Home Manager will receive disciplinary action and will complete mandatory training on the Investigation Process no later than 5/28/2015. The training will include, but is not limited in scope to the following: <ul style="list-style-type: none"> ·Failure to suspend accused staff immediately pending an investigation ·Failure to initiate an investigation ·Failure to report to BDDS or Carey Services or COO for at least 3 days ·Failure to investigate the allegations before administering disciplinary action ·Failure to protect the integrity of the investigation initiated by the Corporate Compliance by reporting to one staff the specifics of the allegation when suspending her. ·Failure to protect the integrity of the investigation initiated by Corporate Compliance by allowing 2 staff to ride to the agency in a company vehicle while suspended. ·The policy and procedure of Abuse, Neglect, Mistreatment and Exploitation will be a standing agenda item at this 	

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	<p>indicated the RM did not complete a report. The CCO's report and investigation indicated the following: "The allegation of neglect was made to and acknowledged by the group home manager (RM) on Saturday and no immediate action was taken as required. Several required actions were disregarded by the group home manager (RM) and include...Failure to report the [allegation] to BDDS or the Carey Services and/or COO for at least 3 days.,,"</p> <p>-An 4/1/15 BDDS report for an incident on 3/26/15 through 3/31/15 (no time given) and a 4/8/15 investigation indicated "Staff reported to the [Residential Manager name] that [GHS (Group Home Staff) #3] was asleep on the couch when they arrived and that is an ongoing occurrence." The RM's and CCO's 4/8/15 investigation indicated "There is a history of staff reporting to [RM] that they either suspect or have witnessed [GHS #3] asleep at morning shift change. Repeated attempts by managers to catch [GHS #3] asleep have failed to do so." The reports indicated staff changed their testimony and the home has "a history of conflict between staff members of different shifts, making it difficult to ascertain whether the reports are sincere."</p>		<p>home's monthly staff meeting to address what is reportable and the required timing of reporting these incidents. The manager will track all staff who attend these mandatory meetings and keep documentation in the manager's working files. The manager is responsible for addressing any staff person who could not attend the mandatory meeting to assure he/she receives the information covered including this standing agenda item.</p> <p>·The manager will initiate interviews with all staff and will include direct questioning about observing any Abuse, Neglect, Mistreatment or Exploitation. The manager will meet with each staff person at least once per month to assure any issue was reported per policy, procedure and state law requires. These interviews will be documented on a form entitled "Reflection Session" and will be submitted to the Director of Group Homes or the Chief Operations Officer in the Director's absence. These interviews at this frequency will occur indefinitely.</p> <p>·The Director of Group Homes and/or Chief Operations Officer will review all submitted documentation from the manager's interviews (staff and consumer interviews) as well as any documentation from Group Home Observation to identify any issues or concerns as related to the topics of reporting ANME or</p>	

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W 0227 Bldg. 00	<p>On 4/28/15 at 12:15pm, an interview with the COO was conducted. The COO indicated the two (2) allegations were not reported immediately to the administrator and to BDDS in accordance with state law. The COO indicated clients #1, #2, #3, #4, and #5 were in the group home when the allegations occurred. The COO indicated the facility staff failed to follow the agency's policy and procedure to protect the clients from abuse, neglect, and/or mistreatment. The COO indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #1), the facility failed to develop a program to address client #1's identified dining recommendation, use of prescribed eye glasses, and client #1's</p>	W 0227	<p>acts of ANME.</p> <p>W227 Individual Program Plan This item outlines that the agency failed to address client #1's (F.N.) dining recommendation, use of prescribed glasses and bathing need. The plan of correction for this tag is as follows:</p>	05/28/2015	

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	<p>bathing need.</p> <p>Findings include:</p> <p>On 4/20/15 from 3:20pm until 6:30pm, client #1 was at the group home with GHS (Group Home Staff) #1 and GHS #2 and the client did not bathe. From 3:20pm until 6:05pm, client #1 was inside her bedroom. Client #1 sat on her bed without her prescribed eye glasses completing a word find with a pencil and without verbal interaction. Client #1's hair was matted to her head in the back. At 5:30pm, GHS #2 indicated client #1 had a body odor from not bathing. GHS #1 indicated the last time client #1 bathed/showered was 3/29/15. GHS #1 and client #1's group home records both indicated client #1 had no record of bathing in 4/2015. The posted bathing calendar was dated 3/2015. At 6:30pm, GHS #1 and GHS #2 indicated client #1 received three (3) meals per day at the group home.</p> <p>On 4/23/15 at 10:00am, client #1's record was reviewed. Client #1's 10/14/14 ISP (Individual Support Plan) had goals/objectives to brush her teeth three times daily, to complete oral hygiene three times daily, to clean and wear her prescribed eye glasses, and did not indicate an objective to bathe. Client #1's</p>		<ul style="list-style-type: none"> ·The mechanism for monitoring FN's bathing was not refreshed and/or staff was not aware of the need to refresh the calendar as evidenced by the calendar not being changed to April 2015. The staff will receive retraining on the hygiene calendar and will locate that calendar in a discrete location whereby FN can make notation herself about her bathing. The client has a history of not wanting to bathe daily and this calendar is the mechanism to promote independence and positive growth whereby the client will document if she completed her hygiene on a given day. ·Staff will receive training before 5/28/2015 on expectations for the calendar in marking bathing. ·Additionally, staff will document in flow sheet on each shift if FN completed her hygiene. ·The Group Home Manager will monitor the hygiene completion at least weekly to assure hygiene needs are met and that staff is compliant with aforementioned training. ·Confirmation will occur via the Group Home Director during monthly visits. ·Dining Recommendation: Staff will be trained, prior to 5/28/2015, on updated dining plan to include encouragement to eat 4-6 (four to six) small meals a day due to diabetes. ·Carey Services Nurse to assure dining plan is updated via 				

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	<p>ISP did not indicate an objective of when client #1 should be prompted to use her prescribed eye glasses. Client #1's record indicated a 2/4/15 "Physician's Order" which indicated "Pt. (Patient) may eat supper in room daily. Pt. needs to be encouraged to eat 4-6 (four to six) small meals a day due to Diabetes." Client #1's 1/15/15 Diabetes Management Plan did not include the recommendations from her physician on 2/4/15. Client #1's 1/20/14 Registered Dietician's review indicated client #1 was on a 1800 calorie regular diet. Client #1's 2/2015 Dining Plan, in the group home, indicated she was on a 1800 calorie diet and client #1's dining plan did not include the recommendation made from her physician on 2/4/15.</p> <p>On 4/24/15 at 11:40am, an interview was conducted with QIDP (Qualified Intellectual Disabilities Professional) #1. QIDP #1 indicated she was unsure if the Registered Dietician was aware of client #1's 2/4/15 physician's recommendation. QIDP #1 indicated she was unsure if client #1 had a bathing goal developed in her ISP.</p> <p>On 4/28/15 at 12:15pm, an interview was conducted with the COO (Chief Operations Officer). The COO indicated client #1 should be prompted for</p>		<p>registered dietician review.</p> <ul style="list-style-type: none"> ·ActiveTreatment: All clients were affected orcould have been affected by this deficient practice. All staff to undergo training on activetreatment no later than 5/28/2015. Therequirement is to provide active treatment at least every 15 minutes, or moreoften. ·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. The documentation will be kept on glassesflow sheet. ·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 and Chief OperationsOfficer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. 	

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W 0249 Bldg. 00	<p>continuous active treatment every fifteen minutes by the facility staff. The COO indicated clients' goals/objectives were in each individual ISP. The COO indicated client #1 was a diabetic and no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to implement ISP (Individual Support Plan) goals/objectives during formal and informal opportunities.</p> <p>Findings include: On 4/20/15 from 3:20pm until 6:30pm, clients #1, #2, #3, and #4 were at the group home with GHS (Group Home Staff) #1 and GHS #2. From 3:20pm until 6:05pm, clients #1 and #4 were inside their bedrooms. Client #1 sat on</p>	W 0249	<p>W249 ProgramImplementation This item outlines that the agency failed to implement ISP goals and objectives during formal and informal opportunities. The plan of correction for this tag is as follows: -Group Home Manager will purchase items to be posted in the home to promote and educate the staff on sign language. Additionally, the manager will purchase resources on sign language for the staff to use with the consumer and will connect with local resources to have a sign language class provided for the staff at this group home. The purchase of materials</p>	05/28/2015

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	<p>her bed without her prescribed eye glasses completing a word find with a pencil and without verbal interaction. Client #1's hair was matted to her head in the back. From 3:20pm until 5:05pm, client #4 sat in a recliner inside her bedroom asleep in the upright position. From 5:05pm until 6:05pm, client #4 sat at the dining room table without activity after receiving her evening medication with GHS #1. From 3:20pm until 6:15pm, client #3 walked in circles around a chair in the living room and paced up/down the hallway. Client #3, on five (5) separate times entered the hallway bathroom to flush the toilet three (3) sequenced times one time after another in the dark bathroom. From 3:20pm until 6:05pm, client #2 walked around the group home living room and dining room, looked at the television, engaged the surveyor in sign language, sat at the dining room table, and used the restroom independently. Client #2 was not prompted or encouraged for activity. At 4:28pm, client #2 and GHS #1 were inside the medication room, client #2 used sign language to indicate he wanted GHS #1 to interact with him. GHS #1 indicated to client #2 that he did not know sign language. Client #2 walked to the bulletin board, pointed to client #1's name on a posted piece of paper for exercises to be completed. GHS #1</p>		<p>will occur no later than 5/28/2015 and will be available at the home. The sign language class may not be able to be completed prior to 5/28/2015, however the class will be scheduled for the first available time slot – the scheduling will occur prior to 5/28/2015.</p> <ul style="list-style-type: none"> ·Active Treatment: All clients were affected or could have been affected by this deficient practice. All staff to undergo training on active treatment no later than 5/28/2015. The requirement is to provide active treatment at least every 15 minutes, or more often. ·Appropriate utensils: staff failed to offer a knife to client MP during mealtime (whereby a goal specifies for MP to use a knife during dining). Staff training to occur to offer all applicable utensils to all consumers at mealtime and staff to encourage their appropriate use unless otherwise indicated by physician's order or by dining plan. ·Bathing: The mechanism for monitoring FN's bathing was not refreshed and/or staff was not aware of the need to refresh the calendar as evidenced by the calendar not being changed to April 2015. The staff will receive retraining on the hygiene calendar and will locate that calendar in a discrete location whereby FN can make notation herself about her bathing. The client has a history of not wanting to bathe daily and this calendar is the mechanism to promote independence and 				

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	<p>looked at client #2 and asked client #2 if he wanted to exercise. Client #2 began clapping and smiling. GHS #1 stated to client #2 "Wait a while and we will do it later." Client #2 walked out of the medication room back into the living room without activity. From 6:05pm until 6:30pm, client #2 set the table with GHS #1 for supper and clients #4 and #5 ground their foods with GHS #2 at the kitchen counter. At 6:15pm, clients #1, #2, #3, and #4 sat down to eat their supper meal. From 6:15pm until 6:30pm, client #3 dropped food onto the table, used his fingers to consume the food from his bowls, and dropped food on the table. No redirection was observed. At 6:30pm, GHS #1 and GHS #2 both indicated they did not know sign language. At 6:15pm, GHS #1 cut and prepared client #2's meat custodially and client #2 was not provided a knife to use at the dining room table. On 4/21/15 at 6:55am, client #2 indicated he did not exercise last night.</p> <p>On 4/23/15 at 10:00am, client #1's record was reviewed. Client #1's 10/14/14 ISP (Individual Support Plan) indicated client #1 wore prescribed eye glasses. Client #1's ISP indicated the following goals/objectives: for client #1 to clean and wear her eye glasses daily, to brush her teeth three times daily, to prepare</p>		<p>positive growth whereby the client will document if she completed her hygiene on a given day.</p> <ul style="list-style-type: none"> ·Staff will receive training before 5/28/2015 on expectations for the calendar in marking bathing. ·Additionally, staff will document in flow sheet on each shift if FN completed her hygiene. ·The Group Home Manager will monitor the hygiene completion at least weekly to assure hygiene needs are met and that staff is compliant with aforementioned training. Confirmation will occur via the Group Home Director during monthly visits. 	

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	<p>menu items following a recipe, to make a purchase in the community, to complete oral hygiene three times daily, to socialize with her peers at least one time daily, and to count out four amounts of money using bills and coins up to \$5.00.</p> <p>On 4/23/15 at 10:30am, client #2's record was reviewed. Client #2's 10/14/14 ISP indicated client #2 wore prescribed eye glasses and used "some" sign language to communicate his wants and needs. Client #2's 10/14/14 ISP indicated the following goals/objectives: for client #2 to wear his eye glasses daily, to learn two (2) signs to communicate with sign language, to apply medicated cream, to make a purchase in the community, to use flushable wipes during toileting, to take his medications, and to safely use a knife during dining.</p> <p>On 4/23/15 at 9:00am, client #3's record was reviewed. Client #3's 3/27/15 ISP indicated the following goals/objectives: to use a napkin during dining, to put soap on his hands after toileting, to wash his legs when bathing, to brush and swab his gums, and to learn sign language for toilet, work, and eat.</p> <p>On 4/23/15 at 9:45am, client #4's record was reviewed. Client #4's 10/14/14 ISP indicated the following goals/objectives:</p>			

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	<p>to locate her risperdone medication, to puree own meals, to brush her teeth three times daily, to wash hands after toileting, to make a purchase in community, to clean her CPAP (Continuous Positive Air Pressure) machine, to take her medications, and to safely use a knife.</p> <p>On 4/20/15 at 5:30pm, GHS #2 indicated client #1 had a body odor from not bathing. Client #1's posted 3/2015 "Bathing Calendar" and GHS #1 indicated it was not for the current month and the last time client #1 bathed/showered was 3/29/15. GHS #1 and client #1's group home records both indicated client #1 had no record of bathing in 4/2015.</p> <p>On 4/24/15 at 11:40am, an interview was conducted with QIDP (Qualified Intellectual Disabilities Professional) #1. QIDP #1 indicated clients #1, #2, #3, and #4 should be prompted and encouraged with activities during formal and informal opportunities every 15 minutes. QIDP #1 indicated staff should implement the goals/objectives as written and prompt clients with activity and interaction. QIDP #1 indicated she was unaware of client #1's bathing needs.</p> <p>On 4/28/15 at 12:15pm, an interview was conducted with the COO (Chief</p>			

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W 0268 Bldg. 00	<p>Operations Officer). The COO indicated clients should be prompted for continuous active treatment every fifteen minutes by the facility staff. The COO indicated staff should implement goals/objectives during formal and informal opportunities.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review, and interview for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 1 additional client #5, the facility failed to ensure a posted sign on client #1, #2, #3, #4, and #5's refrigerator promoted growth and independence.</p> <p>Findings include:</p> <p>On 4/20/15 from 3:20pm until 6:30pm, and on 4/21/15 from 6:55am until 8:30am, clients #1, #2, #3, #4, and #5 had access to the kitchen and the refrigerator. On 4/20/15 from 3:20pm until 4:07pm, an undated colored sign "Poop Pudding. One banana, one cup of applesauce, 1/2 cup of prune juice, one cup of bran flakes, 1/4 cup of raisins, and blend to</p>	W 0268	<p>W268 ConductToward Client This item outlines that the agency failed to ensure a posted sign on the consumers' refrigerator promoted growth and independence. The plan of correction for this tag is as follows: ·The sign was removed prior to the survey exit. The removal was subsequently confirmed. ·Staff training to occur on dignity and respect no later than 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 and Chief Operations Officer during</p>	05/28/2015

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348		
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	<p>desired consistency" was posted on the outside of the refrigerator door. The colored sign had a male cartoon character wearing goggles, a diaper, and a diver's breathing tube in his mouth as the character stood over an open toilet. At 3:40pm, GHS (Group Home Staff) #2 indicated she would not have posted that on her refrigerator at her home. At 3:40pm, GHS #1 indicated the sign did not bother him. At 3:40pm, client #2 was non verbal and held his nose when he looked at the sign. At 3:40pm, client #5 wrinkled her face when she looked at the sign on the refrigerator. GHS #2 indicated the sign was from the agency to remind staff of the recipe for the pudding which promotes a bowel movement and should not have been posted on the refrigerator.</p> <p>On 4/23/15 at 8:50am, an interview was conducted with the Residential Manager (RM). The RM stated the undated colored sign "should probably not" have been posted on the outside of the facility's refrigerator.</p> <p>On 4/28/15 at 12:15pm, an interview with the COO (Chief Operations Officer) was conducted. The COO indicated the "Poop Pudding" recipe and picture should not have been posted on the refrigerator and did not promote growth and</p>		home visits monthly and quarterly respectively. All levels will assure ongoing compliance.		

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W 0436 Bldg. 00	<p>independence of the clients living in the group home.</p> <p>9-3-5(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.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #1 and #2) with adaptive equipment, the facility failed to teach and encourage clients #1 and #2 to wear their prescribed eye glasses at the group home and failed to teach and encourage client #2 to use sign language to communicate.</p> <p>Findings include:</p> <p>On 4/20/15 from 3:20pm until 6:30pm, and on 4/21/15 from 6:55am until 8:30am, clients #1 and #2 did not wear their prescribed eye glasses at the group home. During the observation periods, clients #1 and #2 watched television, looked at magazines, walked throughout the group home, completed medication</p>	W 0436	<p>W436 Space and Equipment This item outlines that the agency failed to teach and encourage clients to wear their prescribed eye glasses at the group home and failed to teach and encourage sign language to communicate where applicable. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> Group Home Manager will purchase items to be posted in the home to promote and educate the staff on sign language. Additionally, the manager will purchase resources on sign language for the staff to use with the consumer and will connect with local resources to have a sign language class provided for the staff at this group home. The purchase of materials will occur no later than 5/28/2015 and will be available at the home. The 	05/28/2015

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	<p>administration, consumed meals, and client #1 stayed in her bedroom writing in a word find puzzle book. During the observation periods, clients #1 and #2 were not observed, taught or encouraged to wear their prescribed eye glasses. During the observation periods, client #2 was not taught and/or encouraged to use sign language to communicate his wants/needs.</p> <p>On 4/23/15 at 10:00am, client #1's record was reviewed. Client #1's 10/14/14 ISP (Individual Support Plan) indicated client #1 wore prescribed eye glasses and included a goal/objective for client #1 to clean and wear her glasses daily.</p> <p>On 4/23/15 at 10:30am, client #2's record was reviewed. Client #2's 10/14/14 ISP indicated client #2 wore prescribed eye glasses and used "some" sign language to communicate his wants and needs. Client #2's 10/14/14 ISP indicated goals/objectives for client #2 to wear his eye glasses daily and to learn two (2) signs to communicate.</p> <p>On 4/28/15 at 12:15pm, an interview was conducted with the COO (Chief Operations Officer). The COO indicated clients #1 and #2 should be prompted to wear their eye glasses at least once a shift. The COO indicated staff should</p>		<p>sign languageclass may not be able to be completed prior to 5/28/2015, however the class willbe scheduled for the first available time slot – the scheduling will occurprior to 5/28/2015.</p> <p>·PrescribedGlasses: All clients that use prescribedglasses are potentially affected by this deficient practice. Staff to be trained on using formal and informalopportunities to use glasses no later than 5/28/2015. Eye Glass Flow sheet will be used to documentif the client is wearing or refusing the eye glasses.</p> <p>·The home managerwill assure compliance during routine group home observations, to occur each daythat the manager is at the home. Thefrequency is generally 5 days out of every 7. Confirmation will occur by Director of Group Homes and Chief OperationsOfficer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</p>		

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W 0440 Bldg. 00	<p>have prompted and encouraged clients #1 and #2 to wear their prescribed eye glasses during waking hours. The COO indicated she was unaware the staff did not know sign language.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 1 additional client (client #5) living in the group home, the facility failed to conduct quarterly evacuation drills for the 7:00am-3:00pm shift of personnel.</p> <p>Findings include:</p> <p>On 4/21/15 at 1:25pm, a review of the facility's evacuation drills from 4/2014 through 4/21/2015 was conducted. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, and #5 after 4/11/2014 at 11:09am to 10/23/14 at 8:11am for the 7:00am-3:00pm shift of personnel.</p> <p>On 4/21/15 at 1:25pm, an interview with the Residential Manager (RM) and the Chief Operations Officer (COO) was</p>	W 0440	<p>W440 Evacuation Drills</p> <p>This item outlines that the agency failed to conduct quarterly evacuation drills from the 7:00AM-3:00PM shift of personnel. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> The home was in transition between one group home manager and another group home manager during the specified time frame. The Group Home Director was not available to assure compliance during the time frame originally indicated to complete this drill. The new Group Home Director will document a new drill calendar assuring that all time frames comply with regulations before 5/28/2015. The new Group Home Manager is responsible to assure drills are completed and submitted per the prescribed schedule that aligns with regulations. Carey Services 	05/28/2015

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	conducted. Both the RM and COO indicated no additional evacuation drills were available for review. 9-3-7(a)		SafetyCommittee will be given a copy of the drill calendar and will include this intheir scope to assure compliance and notify of any missing documentation.		