STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G702	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREY SERVICES INC	7891 E 296TH ST ATLANTA, IN 46031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for a full recertification and state licensure survey. Dates of survey: May 9, 10 and 11, 2012 Surveyor: Kathy Craig, Medical Surveyor III Facility Number: 003179 Provider Number: 15G702 AIMS Number: 200403780 These deficiencies also reflect state findings under 460 IAC 9.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0149	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, the facility failed to implement its abuse/neglect policy by not reporting timely 1 of 2 allegations of abuse regarding 1 of 3 sampled clients (client #2). Findings include: Review on 5/9/12 at 4:30 PM of the facility's records was conducted and included the BDDS (Bureau of Developmental Disabilities Services) incident reports. One BDDS report indicated on 2/20/12, "Upon arriving to work this morning, I [the house manager] was told of an incident that happened on 2/16/12. When passing meds, staff [staff #7], went to [client #2]'s room and banged on her door and started yelling at her to take her meds. [Client #2] had already gone to bed. Staff thought this was very funny and [client #2] began yelling back at her. Another incident with same staff, when [client #2] had made a mess in the bathroom after a bowel movement, same staff made her clean everything up and get on her hands and knees and clean around the toilet." It was reported to BDDS on 2/20/12. It indicated the staff (staff #5)	W0149	**W149** Carey Services must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility failed to implement this policy correctly following an allegation made by a DSP. Specifically, the DSP reported to the manager three days after the incident allegedly occurred. **CORRECTION** Upon Review, it was determined that the delay was due to a DSP failing to immediately report the events in question. When she did mention in to a colleague, it was immediately reported to administration per policy. Staff was suspended and an investigation was implemented by the group home manager immediately upon knowledge of the allegation. The DSP that failed to report was retrained at the time of the incident on Abuse/neglect policy and on procedures for reporting. Additionally, all staff were retrained on these policies on 6/5/2012. **PREVENTION** Carey Services' abuse and neglect reporting policies apply to all consumers. Therefore, training will be increased to assure proper implementation by all staff. In addition to the initial training in	06/06/2012

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	who witnessed the alleged verbal abuse didn't report this incident to the house manager until 2/20/12. The follow-up BDDS report indicated disciplinary action was given to staff #7 for "unprofessional conduct and inappropriate language used while working in the group home." Review on 5/10/12 at 10:45 AM of the facility's accident/incident reports was conducted. The above-described incident occurred on 2/16/12 was dated 2/20/12 and indicated the house manager notified the administrator on 2/20/12. Review on 5/10/12 at 4:30 PM of the facility's "Procedures For Reporting Abuse and Neglect and Other Reportable or Unusual Incidents" dated 4/12, indicated it was the responsibility of each person to report suspected instances of abuse, neglect and exploitation of the clients they serve to the appropriate authorities, as well as agency administrators "immediately upon learning of the suspected abuse/neglect/exploitation." An allegation of abuse was also supposed to be reported to BDDS "no later than 24 hours after the occurrence of the reportable incident." Interview on 5/10/12 at 3:00 PM with the QMRP (Qualified Mental Retardation		Abuse and Neglect that is a part of orientation, a separate review of all applicable policies and procedures will be completed for each new employee by the residential manager. This review will emphasize the critical need for timely reporting. A review of all of these policies will occur every four months, or more often, to assure retention of the information. **MONITORING** The Director of Group Homes/QMRP will track abuse/neglect training to assure that timelines are met. Additionally, the Residential Manager will regularly test DSP knowledge of correct procedures for reporting abuse, neglect, and other incidents.	

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	Professional) was conducted. The QMRP indicated the above-mentioned incident was reported late. The QMRP indicated staff #5 did not report this allegation to her supervisor immediately. She indicated their policy indicated allegations of abuse/neglect were to be reported to the administrator immediately. 9-3-2(a)			

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W0153	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, the facility failed to report timely 1 of 2 allegations of abuse regarding 1 of 3 sampled clients (client #2) immediately to the administrator and to BDDS (Bureau of Developmental Disabilities Services) within 24 hours after the incident in accordance with State law. Findings include: Review on 5/9/12 at 4:30 PM of the facility's records was conducted and included the BDDS incident reports. One BDDS report indicated on 2/20/12, "Upon arriving to work this morning, I [the house manager] was told of an incident that happened on 2/16/12. When passing meds, staff [staff #7], went to [client #2]'s room and banged on her door and started yelling at her to take her meds. [Client #2] had already gone to bed. Staff thought this was very funny and [client #2] began yelling back at her. Another incident with same staff, when [client #2] had made a mess in the bathroom after a bowel movement, same staff made her	W0153	**W153** Carey Services must ensure that all allegations of mistreatment, neglector abuse, as well as injuries of unknown source, are reported immediately to theadministrator or to other officials in accordance with State law through establishedprocedures. The facility failed to meet this standard, as an allegation of verbal abuse was not reported immediately. Specifically, the DSP reported to the manager three days after the incident allegedly occurred. Because of this delay, the report to the administrator was also delayed. **CORRECTION** Upon Review, it was determined that the delay was due to a DSP failing to immediately report the events in question. When she did mention in to a colleague, it was immediately reported to administration per policy. Staff was suspended and an investigation was implemented by the group home manager immediately upon knowledge of the allegation. The DSP that failed to report was retrained at the time of the incident	06/05/2012

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	clean everything up and get on her hands and knees and clean around the toilet." It was reported to BDDS on 2/20/12. It indicated the staff (staff #5) who witnessed the alleged verbal abuse didn't report this incident to the house manager until 2/20/12. The BDDS follow-up report dated 2/28/12 indicated disciplinary action was given to staff #7 "for unprofessional conduct and inappropriate language used while working in the group home." Review on 5/10/12 at 10:45 AM of the facility's accident/incident reports was conducted. The above-described incident occurred on 2/16/12 was dated 2/20/12 and indicated the house manager notified the administrator on 2/20/12. Interview on 5/10/12 at 3:00 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated the above-mentioned incident was reported late. The QMRP indicated staff #5 did not report this allegation to her supervisor immediately. She indicated allegations of abuse/neglect are to be reported immediately to the administrator. 9-3-2(a) 9-3-1(b)(5)		on Abuse/neglect policy and on procedures for reporting. Additionally, all staff were retrained on these policies on 6/5/2012. **PREVENTION** Immediate reporting of allegations is critical for all residents, and overall training must be increased to assure compliance. In addition to the initial training in Abuse and Neglect that is a part of orientation, a separate review of all applicable policies and procedures will be completed for each new employee by the residential manager. This review will emphasize the critical need for timely reporting. A review of all of these policies will occur every four months, or more often, to assure retention of the information. This review policy was implemented on 6/5/2012. **MONITORING** The Director of Group Homes/QMRP will track abuse/neglect training to assure that timelines are met. Additionally, the Residential Manager will regularly test DSP knowledge of correct procedures for reporting abuse, neglect, and other incidents.	

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client #3) and 1 additional client (client #6) by not implementing their program goals when the opportunity arose. Findings include: Observations were conducted on 5/9/12 from 3:30 PM to 6:30 PM at the group home. At 4:10 PM, client #3 received 2 medications at the 4 PM med (medication) pass. Staff #4 put the meds in applesauce in a cup and gave it to client #3. Review on 5/10/12 at 1:00 PM of client #3's records was conducted. His ISP (Individual Support Plan) dated 10/20/11 included a med goal to put medication in applesauce with staff using hand over hand. During observations on 5/9/12 from 3:30 PM to 6:30 PM at the home, at 4:20 PM,	W0249	**W249** Carey Services must assure that a client receives a continuous active treatment program. The facility failed to meet this standard on two occasions during the survey process. Specifically, staff failed to allow client #3 to put medications in applesauce using hand-over-hand. Additionally, staff did not intervene by verbally redirecting Client #6 from her increasing self injurious behavior per her behavior plan, instead telling her to "hang on." **CORRECTION** Staff will be trained on how formal and informal training related to medication administration goals. Additionally, Client #6's behavior plan will be reviewed to assure that all staff are aware of the correct interventions during self-injurious behavior. All training will take place on 6/5/2012. **PREVENTION** Active treatment is required for all residents, and therefore staff must maintain these protocols at all	06/05/2012

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	client #6 was wheeled into the area where her meds were to be given. Client #6 immediately began hitting herself with her fists on her forehead and was screaming and yelling. From 4:20 PM to 4:25 PM, client #6 continued to punch herself and hit herself in the face. Staff #4, who was getting client #6's meds ready, did not intervene. Staff #4 stated "hold on babe" but did not redirect her. At 4:25 PM, the house manager came into the area and proceeded to redirect client #6. Review on 5/11/12 at 1:15 PM of client #6's records was conducted Client #6's Behavior Support Plan dated December 2011 indicated client #6 had SIB (Self-Injurious Behavior), which included but was not limited to, biting hands, wrists and arms and hitting chin head and nose, and kicking and knocking her knuckles on surfaces. It indicated when client #6's SIB becomes "increasingly frequent and intense," staff was to offer client #6 verbal redirection and warning. Also, after 3 verbal warnings, staff were to hold her hands down in her lap for 60 seconds. Interview on 5/10/12 at 3:05 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated the med goals should be		times. Staff will be trained on the implementation of formal and informal goals and active treatment protocols. To assure that all staff keep medication goals "top of mind," a list of consumer medication administration goals will be placed in the medication book with the Client MAR, and a list of informal training options will be posted by the medication cart. All preventative measures will be implemented on 6/5/2012 To assure that appropriate behavioral interventions are utilized by staff, the review if a client behavior plan will be conducted at each monthly staff meeting, and rotated throughout the year. This will be implemented at the staff meeting scheduled for 6/5/2012. **MONITORING** The Residential nurse, Residential manager, or Director of Group Homes will conduct at least two random weekly observations to ensure that continuous active treatment is being provided during medication passes. This will be tracked for a period of six months and discontinued if there are no noted ongoing concerns. Monitoring will begin the week of 6/4/2012.	

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	implemented anytime during med pass. Interview on 5/11/12 at 2:36 PM with the QMRP was conducted. The QMRP indicated staff #4 should have followed client #6's behavior plan. 9-3-4(a)			

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W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview, the facility failed to administer without error 1 out of 2 medications for 1 of 3 sampled clients (client #1). Findings include: Observations were conducted at the group home on 5/9/12 from 3:30 PM to 6:30 PM. During the 4:00 PM med (medication) pass, staff #4 administered to client #1 one 1000 mg (milligram) Fish Oil tablet at 4:15 PM. On the pill packet, it indicated it was to be taken with meals. There was no food or snack given to client #1 with the Fish Oil. Client #1 started eating supper at 5:45 PM, 1 1/2 hours after taking her Fish Oil. Review on 5/9/12 at 6:15 PM of client #1's MAR (Medication Administration Record) dated 5/9/12 indicated she was to take her Fish Oil with meals. Review on 5/10/12 at 11:35 AM of client #1's records was conducted. Client #1's most current Physician's Orders (PO) signed by the physician on 2/16/12 indicated client #1 was to take 1000 mg	W0369	**W369** Carey Services must assure that drugs are administered without error. The facility failed to meet this standard for one medication during the survey process. Specifically, client #1 did not have a meal within 30 minutes of taking fish oil, as ordered. Upon investigation, it was determined that the reason for the error was that the meal was delayed by the installation of flooring. The clients were on an outing, and planned to eat out, but returned to take part in the survey. Meals were ordered out, and did not arrive within the 30 minute timeframe. While this was an unusual circumstance, it was also preventable. **CORRECTION** Client #1's orders stated that the fish oil must be taken with meals. To allow for more flexibility, the order was changed to "with food." With this order change, staff will give the consumer a snack from the medication cart when giving the fish oil. The order was obtained on 6/1/2012. **PREVENTION** No other clients at the Atlanta	06/01/2012

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	Fish Oil tablet 3 times daily with meals. Interview on 5/10/12 at 3:20 PM with the facility nurse was conducted. She indicated client #1 should have eaten food within 30 minutes of taking her Fish Oil. 9-3-6(a)		Group Home have orders for medications requiring that they be taken with food. Any new orders that require a “with meals” protocol will be individually evaluated to determine if the order can be made to be more flexible in its requirements by changing the order to “with food.” All staff will be retrained on physician orders and proactive planning for administration challenges on 6/5/2012. **MONITORING** The Residential nurse, Residential manager, or Director of Group Homes will conduct at least two random weekly observations to ensure that fish oil is being administered per physician’s orders. This will be tracked for a period of six months and discontinued if there are no noted ongoing concerns. Monitoring will begin the week of 6/4/2012.	

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W0426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Based on observation, record review and interview, the facility failed for 2 of 6 clients who resided in the home (clients #2 and #6) to ensure the water temperature (temp) in the home was not over 110 degrees. Findings include: Observations were conducted at the group home on 5/9/12 from 3:30 PM to 6:30 PM, where clients #2 and #6 resided. A water temperature for the hot water was taken at the group home kitchen sink and it registered at 120 degrees. The bathroom on the northeast side of the home's water temperature registered at 120 degrees. The bathroom on the northwest side of the home's water temperature registered at 122 degrees. After supper, the house manager ran the water in the kitchen sink for the dishes and checked the water temp by hand. Client #2 helped the house manager wash the dishes after the house manager had ran the water herself. Interview on 5/9/12 at 5:10 PM with the	W0426	**W426** Carey Services must ensure that the temperature of accessible water does not exceed 110 degrees Fahrenheit. The facility failed to meet this standard as measured during the survey, as two tests were above the maximum temperature allowable. Upon investigation, it was determined that the water temperature had been within normal limits for several readings prior to the survey. As appliances were disconnected and water lines were manipulated during the installation of the flooring, this may have impacted water temperature. **CORRECTION** Water temperature was adjusted on 5/11/2012 to assure compliance. Current water temperatures are within the correct temperature range. **PREVENTION** All consumers require the regulation of water temperature. As a preventative measure, a new mixing valve was installed on 5/11/2012. Water temperatures will be measured daily for a period of one month to assure temperature is	06/05/2012

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	QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated she would call the maintenance man about the water temps. Observations were conducted at the group home on 5/10/12 from 7:04 AM to 7:55 AM. The kitchen sink water temp for the hot water was 128.4 degrees. Review on 5/11/12 at 4:05 PM of client #6's water temp assessment indicated client #6 could not regulate hot and cold water faucets as of 10/6/11. There was no water temp assessment for client #2 available for review on 5/11/12. Interview on 5/10/12 at 3:00 PM with the QMRP was conducted. The QMRP indicated the water temperature should be from 100 to 110 degrees. 9-3-7(a)		maintained. Additionally, staff will be retrained on water measurement on 6/5/2012, to assure accuracy of readings and to verify that the protocols for out-of-range water temperatures are clear. **MONITORING** See above. Water temperature will be monitored daily by direct care staff and reviewed by the Director of Group Homes for a period of one month. If water temperatures remain within the correct range, water temperature assurance protocols will return to weekly checks. Daily monitoring began on 5/30/2012.	

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7891 E 296TH ST ATLANTA, IN 46031	

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W9999	State Findings This Community Residential Facilities Rule was not met for Persons with Developmental Disabilities. 460 IAC 9-3-2 Resident Protections (c)(3) The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. This state rule was not met as evidenced by: Based on administrative record review and interview, the facility failed for 2 of 3 newest staff persons reviewed, staff #2, by having only two references and no criminal or driver checks, and staff #3 who did not have a criminal or driver check. Findings include: Review on 5/10/12 at 2:35 PM of staff #2's personnel records indicated staff #2 was hired 2/20/12. There was no criminal check or driver's check and only 2 references in her file.	W9999	**State rule 9999** Carey Services must comply with the Indiana Administrative Code regarding resident protections. The facility did not meet this standard in the area of human resources documentation. Specifically, required information on background checks was not present in two employee records. Upon investigation, it was determined that the reason for the oversight was that HR had a new individual in the HR assistant position. In the transition between the HR Generalist to the HR Assistant the checks were not completed, one thinking that the other had done them. One employee only submitted two references because she had only had two previous positions. **CORRECTION** The two personnel files were reviewed on 5/22/2012. All are now in compliance, with the exception of a single reference. This reference will be obtained no later than 6/8/2012. **PREVENTION** Incomplete personnel records apply to all residents at the facility. To assure compliance, a full audit was completed, and all records verified	06/08/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G702	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/11/2012

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	Review on 5/10/12 at 2:36 PM of staff #3's personnel records indicated staff #3 was hired 2/20/12. There was no criminal check or driver's check in her file. Interview on 5/10/12 at 2:40 PM with the Human Resources director indicated they did not obtain a third reference, criminal or driver's check on staff #2, and did not obtain a criminal or driver's check on staff #3. 9-3-2(c)(3)		on 5/22/2012. Additionally, a new checklist was developed for use in HR to assure that new hires have all necessary documentation. This checklist was implemented on 5/22/2012. **MONITORING** The above HR checklist will be completed for all new employees. The checklist was initiated on 5/28/2012, and will be Monitored by the HR manager.	