

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000  Bldg. 00	<p>This visit was for the investigation of Complaint #IN00162895.</p> <p>Complaint #IN00162895: Substantiated, Federal/state deficiencies related to the allegations are cited at W149, W153, W154, W157, and W249.</p> <p>Dates of Survey: 2/25, 2/26, 2/27, 3/2, 3/3, 3/4, 3/5, and 3/6/2015.</p> <p>Facility number: 000644 Provider number: 15G107 AIM number: 100234170</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 17, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 9 of 10 allegations (for</p>	W 149	<b>W149 StaffTreatment of Clients</b> This item outlines that the agency failed to implement its	04/05/2015

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:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>clients A, B, C, D, E, and F) reported and for 9 of 27 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 A, B, C, D, E, and F immediately to the administrator and to BDDS in accordance with state law, neglected to ensure staff were available and supervised clients at the group home, neglected to complete thorough investigations, and neglected to complete effective corrective action after allegations of abuse, neglect, and/or mistreatment.</p> <p>Findings include:</p> <p>On 2/25/15 from 5:15pm until 6:15pm, clients A, B, C, D, and E were observed at the group home with GHS (Group Home Staff) #3 and #5. Client F was not present at the group home. At 5:15pm, GHS #5 stated she "did take food from [client F] because she would eat too fast and would take the plate away" from client F. At 5:15pm, client C stated she "sometimes got coffee" to drink and indicated she would like to have coffee to drink. At 5:15pm, client A stated "Yes, [GHS #5] took my walker away" from</p>		<p>Abuse, Neglect and/or Mistreatment policy and procedure to immediately report allegations of staff to client abuse, neglect and/or mistreatment to the administrator and to BDDS in accordance with state law. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>·All clients were affected by this deficiency.</li> <li>·Mandatory Training on Abuse, Neglect, Mistreatment and Exploitation and Timing of such reportable incidents will occur no later than 4/5/2015 with all staff.</li> <li>·Mandatory Training on ISPs, Risk Plans and BSPs will occur with all staff no later than 4/5/2015.</li> <li>·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 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.</li> <li>·The monitoring agent will be the manager of the home will</li> </ul>	

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  03/06/2015	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>me before. At 5:30pm, the current Residential Manager (RM) stated it was not part of "any" client plans to take food away from them, to remove "any" clients' plate, or to remove "any" clients' walker from the client. The RM indicated she began working as the group home RM on 2/1/15. The RM indicated she had been retraining staff to provide coffee and interactions with clients. At 5:35pm, clients B and E were non verbal and made their needs known through gestures, facial expressions, and vocalizations. At 5:35pm, clients A and D stated they would not report staff who were "mean" to them.</p> <p>On 2/25/15 at 4:15pm, and on 2/26/15 at 9:30am, the facility's BDDS Reports and investigations were reviewed from 12/2015 through 02/25/15. The review indicated the following.</p> <p>-A 2/6/15 BDDS report for an incident reported on 2/5/15 at 12:15pm. The BDDS report indicated client F "was alleging physical abuse from [GHS (Group Home Staff) #5]" and the report indicated GHS #5 was "suspended immediately." The report indicated the "Allegation was not substantiated. Investigation was completed." The report indicated client F had "hallucinations... (and) It was reported that [GHS #5]</p>		<p>document observations for at least 5days out of every 7 per week. The frequency will increase if any ANME incidents are noted or found during the intensive observation period. The manager will document observation on a "Group Home Observation" form and will submit this to the Director of Group Homes or to the Chief Operations Officer if the Director of Group Homes is a vacant position or is not available. These observations will occur at this frequency for at least one month. At that time, the manager and the Director of Group Homes (or the Chief Operations Officer) will re-evaluate the frequency and determine if less frequent documented observations is appropriate.</p> <p>The manager will interview clients, at least one client per day in which an observation occurs (as described above). To assure that the client feels that he/she is safe, secure, and free of abuse, neglect, mistreatment or exploitation. These interviews will be documented and will be submitted to the Director of Group Homes or the Chief Operations Officer in the Director's absence. These documented interviews will occur at this frequency for at least one month. At that time, the manager and the Director of Group Homes (or the Chief Operations Officer) will re-evaluate the frequency and</p>				

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  03/06/2015
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>allegedly hit [client F] on her left arm while [client F] was in her chair in her bedroom. Investigation yielded that the alleged staff was not in the consumer's room."</p> <p>-A 1/12/15 BDDS report for an incident on 1/10/15 at 5:30pm, reported on 1/12/15 to the administrator. The report indicated "It was reported on Saturday 1/10/15 that [GHS #5] has been abusive and neglectful towards [clients A and F]. According to the report [GHS #5] will take [client F's] plate of food away from in front of her due to eating rapidly. [GHS #5] will return the food and prompt [client F] to eat slower. After the third incidents of having to remove the food away, it is reported that [GHS #5] would puree [client F's] food. [Client F] is on a mechanical soft diet with ground meats. According to the report [GHS #5] would take [client A's] rollator walker from her as a punishment for falling asleep in the living room after dinner. [GHS #5] would also have [client A] walk laps from one end of the house to the other end of the house without the use of the walker."</p> <p>-The 1/12/15 investigation into the incident on 1/10/15 at 5:30pm, indicated the allegation was unsubstantiated and "staff will be retrained on the dining and</p>		<p>determine if less frequent documented observations is appropriate.</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. 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.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2015	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dysphagia management plans." The investigation included witness statements from GHS #1, GHS #3, GHS #4, and GHS #5. GHS #3 and GHS #4's witness statements indicated a new/different allegation regarding allegations of verbal abuse reported to them by GHS #2 against GHS #5. The investigation did not include witness statements from GHS #2 and/or retraining staff on immediately reporting allegations in accordance with state law.</p> <p>-A 1/12/15 BDDS report for an incident on 1/12/15 at 7:00am, indicated "It was reported that on Saturday 1/10/15 that [GHS #1] was verbally aggressive towards [client F] in an increased volume and by telling [client F] to shut the f--- up. According to information gathered from the investigation with staff and consumers present during the alleged time. The allegation of verbal abuse was unsubstantiated." The report indicated the corrective measure was "the policy" will be reviewed "at the staff meeting 1/16/15."</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 7:00am, indicated an "Unknown origin" injury for client F. The report indicated client F was seen at the local emergency room after "complaining her wrist was hurting...a sling type wrap was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>applied to the right wrist and hand...DX (Diagnosis) right wrist strain, DJD (Degenerative Joint Disease), Right middle pharynx finger fracture." No cause of the injury was available for review. The follow up BDDS report indicated "the nurse noticed bruising of older colors" on client F's hand and finger. The report indicated the group home staff had signed skin checks for the previous days and no record was recorded of client F's injury or skin discoloration.</p> <p>-A 12/12/14 BDDS report for an incident reported on 12/11/14 to the administrator and occurring on 12/10/14 at 6:00pm, indicated client F reported that "she was not allowed to have coffee on the evening of 12/10/14 time is unknown." The report indicated the Residential Director (RM) on that date "gathered" information that clients B and F "was not to have coffee" and the RM "told the staff" that clients B and F "was entitled to have coffee (sic)." The report indicated "additional disciplinary action will be taken due to this being the second incident of this staff withholding coffee to [clients B and F] causing behaviors of physical aggression (sic)." On 2/27/15 at 9:45am, the Chief Operations Officer (COO) indicated GHS #5 was the identified staff person involved.</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	-A 12/8/14 BDDS report for an incident reported on 12/6/14 to the administrator and occurring on 12/6/14 at 6:35pm, indicated the agency Registered Nurse (RN) "arrived" to the group home at 6:35pm to perform nursing visits. The report indicated "upon entry of the home consumers [clients A, B, C, D, E, and F] were noted to be sitting at the dining room table eating supper. [The agency RN] noted that no staff were present. When going to office to drop off materials, one staff member came out of the restroom...[The agency RN] went to look for staff and the one staff was speaking through the back door to someone." The report indicated the other staff was outside smoking. The investigation indicated clients were not eating without staff present and were seated at the dining room table. The investigation indicated the staff outside was able to see the clients at the dining room table and indicated the allegation was unsubstantiated. The investigation indicated GHS #5 was the staff outside smoking during the incident. The investigation indicated clients A, B, C, D, E, and F "required 24 hour a day staff supervision. Yes it is determined that staff should have been with the consumers during meals. This will be addressed through disciplinary action including retraining of all home staff."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>No corrective action was available for review.</p> <p>On 2/28/15 at 4:30pm, the COO provided additional BDDS reports for review of allegations of abuse, neglect, and/or mistreatment which indicated the following.</p> <p>-A 2/28/15 BDDS report for an allegation on 2/28/15 at 2:05pm, indicated "staff reports to [COO] that when 2nd shift reports for their shift upon entering...the second shift staff noticed that [client C] in a w/c (wheelchair) her alarm was going off and [client B] was needing assistance making coffee and staff was sitting in a chair with [GHS #1 and #4's] legs over the side of the arm (talking) on her cell phone and did not help the consumer at the needed assistance at the time (sic)."</p> <p>-A 2/28/15 BDDS report for an allegation on 2/28/15 at 2:05pm, indicated "received a call from staff stating that another staff was getting aggravated with some noises that [client B] was making. Staff started yelling at the client to stop making the noises...[Client B] started making the noises again. Staff then proceeded to start pushing very violently the client into the counter while seated. Then [the staff] took the client's food</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>away from her." The report indicated staff was suspended pending investigation and "the team will monitor."</p> <p>On 3/4/15 at 10am, the 3/3/15 follow up BDDS report to the allegation regarding staff not supervising clients and talking on their cell phone was "substantiated" and indicated staff "will be retrained."</p> <p>The 3/2/15 investigation indicated GHS #5 was terminated from employment for "continued" inappropriate interactions with clients.</p> <p>On 2/25/15 at 4:15pm, an interview with the COO (Chief Operations Officer) was conducted. The COO stated clients A, B, C, D, E, and discharged client F "required" twenty-four hour a day, seven days a week staff supervision. The COO stated clients A, B, C, D, E, and F "required" and should have staff supervision while eating, cooking, pouring coffee, and living in the group home. The COO indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations.</p> <p>On 2/26/15 at 12:40pm, an interview with the COO (Chief Operations Officer) was conducted. The COO indicated the group home staff to client inappropriate interactions were investigated for each</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>incident and staff were to have been retrained after each incident. The COO indicated the QIDP (Qualified Intellectual Disabilities Professional) was on a Leave of Absence at this time and not all trainings had been accounted for. The COO stated the report for client B on 2/26/15 should have included that GHS #5 "had removed a blanket roughly off" of client B who was asleep on the sofa in the living room at the time. The COO indicated the staff involved was immediately suspended. The COO indicated the facility staff did not protect clients A, B, C, D, E, and F from further staff abuse, neglect, and/or mistreatment when they failed to immediately report the incidents for allegations immediately to the administrator. The COO indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect/and/or mistreatment. The COO indicated when they became aware of the incident they took immediate action. The COO indicated during each incident the staff person finished their shift of work until the allegation incident was reported to the agency. The COO indicated the facility's corrective measures were not effective when the allegations and incidents continued to occur. No further information was available for review.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/6/15 at 7:35am, an interview with the COO was conducted. The COO indicated no further information was available for review.</p> <p>The facility's records were reviewed on 02/25/15 at 4:15pm. 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 equipment (as indicated in the ISP (Individual Support Plan))."</p> <p>The facility's 6/2011 "Procedures for Reporting abuse, neglect, and other Reportable or Unusual Incidents" indicated "As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and exploitation...Staff and volunteers are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153 Bldg. 00	<p>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>This federal tag relates to complaint #IN00162895.</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, for 3 of 10 allegations reported to BDDS (Bureau of Developmental Disabilities Services) reviewed (clients A, B, and F), the facility staff failed to immediately report an allegation of staff to client abuse, neglect, and/or mistreatment to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law 9-3-1(b)(5).</p>	W 153	<p><b>W153 StaffTreatment of Clients</b> This item outlines that the agency failed to immediately report an allegation of staff to client abuse, neglect and/or mistreatment to the administrator and to BDDS in accordance with state law. The plan of correction for this tag is as follows:  ·All clients were affected by this deficiency.</p>	04/05/2015

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>On 2/25/15 at 4:15pm, and on 2/26/15 at 9:30am, the facility's BDDS Reports and investigations were reviewed from 12/2015 through 02/25/15. The review indicated the following.</p> <p>-A 1/12/15 BDDS report for an incident on 1/10/15 at 5:30pm, reported on 1/12/15 to the administrator. The report indicated "It was reported on Saturday 1/10/15 that [GHS #5] has been abusive and neglectful towards [clients A and F]. According to the report [GHS #5] will take [client F's] plate of food away from in front of her due to eating rapidly. [GHS #5] will return the food and prompt [client F] to eat slower. After the third incidents of having to remove the food away, it is reported that [GHS #5] would puree [client F's] food. [Client F] is on a mechanical soft diet with ground meats. According to the report [GHS #5] would take [client A's] rollator walker from her as a punishment for falling asleep in the living room after dinner. [GHS #5] would also have [client A] walk laps from one end of the house to the other end of the house without the use of the walker."</p> <p>-The 1/12/15 investigation into the</p>		<ul style="list-style-type: none"> <li>·Mandatory Training on Abuse, Neglect, Mistreatment and Exploitation and Timing of such reportable incidents will occur no later than 4/5/2015 with all staff.</li> <li>·Mandatory Training on ISPs, Risk Plans and BSPs will occur with all staff no later than 4/5/2015.</li> <li>·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 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.</li> <li>·The monitoring agent will be the manager of the home will document observations for at least 5 days out of every 7 per week. The frequency will increase if any ANME incidents are noted or found during the intensive observation period. The manager will document observation on a "Group Home</li> </ul>	

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  03/06/2015
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>incident on 1/10/15 at 5:30pm, indicated the allegation was unsubstantiated and "staff will be retrained on the dining and dysphagia management plans." The investigation included witness statements from GHS #1, GHS #3, GHS #4, and GHS #5. GHS #3 and GHS #4's witness statements indicated a new/different allegation regarding allegations of verbal abuse reported to them by GHS #2 against GHS #5. The investigation did not include witness statements from GHS #2 and/or retraining staff on immediately reporting allegations in accordance with state law.</p> <p>-A 1/12/15 BDDS report for an incident on 1/12/15 at 7:00am, indicated "It was reported that on Saturday 1/10/15 that [GHS #1] was verbally aggressive towards [client F] in an increased volume and by telling [client F] to shut the f--- up. According to information gathered from the investigation with staff and consumers present during the alleged time. The allegation of verbal abuse was unsubstantiated." The report indicated the corrective measure was "the policy" will be reviewed "at the staff meeting 1/16/15."</p> <p>-A 12/12/14 BDDS report for an incident reported on 12/11/14 to the administrator and occurring on 12/10/14 at 6:00pm,</p>		<p>Observation" form and will submit this to the Director of Group Homes or to the Chief Operations Officer if the Director of Group Homes is a vacant position or is not available. These observations will occur at this frequency for at least one month. At that time, the manager and the Director of Group Homes (or the Chief Operations Officer) will re-evaluate the frequency and determine if less frequent documented observations is appropriate.</p> <p>-The manager will interview clients, at least one client per day in which an observation occurs (as described above). To assure that the client feels that he/she is safe, secure, and free of abuse, neglect, mistreatment or exploitation. These interviews will be documented and will be submitted to the Director of Group Homes or the Chief Operations Officer in the Director's absence. These documented interviews will occur at this frequency for at least one month. At that time, the manager and the Director of Group Homes (or the Chief Operations Officer) will re-evaluate the frequency and determine if less frequent documented observations is appropriate.</p> <p>-The manager will initiate interviews with all staff and will include direct questioning</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2015	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated client F reported that "she was not allowed to have coffee on the evening of 12/10/14 time is unknown." The report indicated the Residential Director (RM) on that date "gathered" information that clients B and F "was not to have coffee (sic)" and the RM "told the staff" that clients B and F "was entitled to have coffee (sic)." The report indicated "additional disciplinary action will be taken due to this being the second incident of this staff withholding coffee to [clients B and F] causing behaviors of physical aggression." On 2/27/15 at 9:45am, the Chief Operations Officer (COO) indicated GHS #5 was the identified staff person involved.</p> <p>On 2/25/15 at 4:15pm, an interview with the COO (Chief Operations Officer) was conducted. The COO indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations.</p> <p>On 2/26/15 at 12:40pm, an interview with the COO (Chief Operations Officer) was conducted. The COO indicated the group home staff to client inappropriate interactions were investigated for each incident and staff were to have been retrained after each incident. The COO indicated the QIDP (Qualified Intellectual Disabilities Professional) was</p>		<p>aboutobserving any Abuse, Neglect, Mistreatment or Exploitation. The manager will meet with each staff personat least once per month to assure any issue was reported per policy, procedureand state law requires. These interviewswill be documented on a form entitled "Reflection Session" and will be submittedto the Director of Group Homes or the Chief Operations Officer in the Director'sabsence. These interviews at thisfrequency will occur indefinitely.</p> <p>·The Director ofGroup Homes and/or Chief Operations Officer will review all submitteddocumentation from the manager's interviews (staff and consumer interviews) aswell as any documentation from Group Home Observation to identify any issues orconcerns as related to the topics of reporting ANME or acts of ANME.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>on a Leave of Absence at this time and not all trainings had been accounted for. The COO stated the report for client B on 2/26/15 should have included that GHS #5 "had removed a blanket roughly off" of client B who was asleep on the sofa in the living room at the time. The COO indicated the staff involved was immediately suspended. The COO indicated the facility staff did not protect clients A, B, C, D, E, and F from further staff abuse, neglect, and/or mistreatment when they failed to immediately report the incidents for allegations immediately to the administrator. The COO indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect/and/or mistreatment. The COO indicated when they became aware of the incident they took immediate action. The COO indicated during each incident the staff person finished their shift of work until the allegation incident was reported to the agency. No further information was available for review.</p> <p>On 3/6/15 at 7:35am, an interview with the COO was conducted. The COO indicated no further information was available for review.</p> <p>This federal tag relates to complaint #IN00162895.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2015	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 154  Bldg. 00	<p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review, and interview, for 5 of 10 allegations of abuse, neglect, and/or mistreatment (for clients A, B, and F), the facility failed to complete thorough investigations for allegations of abuse, neglect, and/or mistreatment.</p> <p>Findings include:</p> <p>On 2/25/15 from 5:15pm until 6:15pm, clients A, B, C, D, and E were observed at the group home with GHS (Group Home Staff) #3 and #5. Client F was not present at the group home. At 5:15pm, GHS #5 stated she "did take food from [client F] because she would eat too fast and would take the plate away" from client F. At 5:15pm, client C stated she "sometimes got coffee" to drink and indicated she would like to have coffee to drink. At 5:15pm, client A stated "Yes, [GHS #5] took my walker away" from me before. At 5:30pm, the current Residential Manager (RM) stated it was not part of "any" client plans to take food</p>	W 154	<p><b>W154 Staff Treatment of Clients</b></p> <p>This item outlines that the agency failed to complete thorough investigations for allegations of abuse, neglect and/or mistreatment. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>·All clients were affected by this deficient practice.</li> <li>·Management will receive mandatory training on the Investigation Process with the Corporate Compliance Officer no later than 4/5/2015.</li> <li>·The agency's Corporate Compliance Officer will be monitoring this process by tracking all documentation of all ANME investigations to assure timely and thorough completion with all required components included.</li> <li>·The agency's Corporate Compliance Officer will meet at least once per month with director-level management to</li> </ul>	04/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2015
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>away from them, to remove "any" clients' plate, or to remove "any" clients' walker from the client. The RM indicated she began working as the group home RM on 2/1/15. The RM indicated she had been retraining staff to provide coffee and interactions with clients. At 5:35pm, clients B and E were non verbal and made their needs known through gestures, facial expressions, and vocalizations. At 5:35pm, clients A and D stated they would not report staff who were "mean" to them.</p> <p>On 2/25/15 at 4:15pm, and on 2/26/15 at 9:30am, the facility's BDDS Reports and investigations were reviewed from 12/2015 through 02/25/15. The review indicated the following.</p> <p>-A 1/12/15 BDDS report for an incident on 1/10/15 at 5:30pm, reported on 1/12/15 to the administrator. The report indicated "It was reported on Saturday 1/10/15 that [GHS #5] has been abusive and neglectful towards [clients A and F]. According to the report [GHS #5] will take [client F's] plate of food away from in front of her due to eating rapidly. [GHS #5] will return the food and prompt [client F] to eat slower. After the third incidents (sic) of having to remove the food away, it is reported that [GHS #5] would puree [client F's] food. [Client F]</p>		<p>identify any trends that may be occurring.</p> <p>The agency's Corporate Compliance Officer will identify staff-specific trends to identify situations whereby repeated allegations are made toward the same employee and will discuss this with the Chief Operations Officer, the Director of Human Resources and Staff Development and/or the Chief Executive Officer as appropriate. This monitoring will occur on an ongoing basis as allegations made and investigations are initiated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2015	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>is on a mechanical soft diet with ground meats. According to the report [GHS #5] would take [client A's] rollator walker from her as a punishment for falling asleep in the living room after dinner. [GHS #5] would also have [client A] walk laps from one end of the house to the other end of the house without the use of the walker."</p> <p>-The 1/12/15 investigation into the incident on 1/10/15 at 5:30pm, indicated the allegation was unsubstantiated and "staff will be retrained on the dining and dysphagia management plans." The investigation included witness statements from GHS #1, GHS #3, GHS #4, and GHS #5. GHS #3 and GHS #4's witness statements indicated a new/different allegation regarding allegations of verbal abuse reported to them by GHS #2 against GHS #5. The investigation did not include witness statements from GHS #2 and/or retraining staff on immediately reporting allegations in accordance with state law.</p> <p>-A 1/12/15 BDDS report for an incident on 1/12/15 at 7:00am, indicated "It was reported that on Saturday 1/10/15 that [GHS #1] was verbally aggressive towards [client F] in an increased volume and by telling [client F] to shut the f--- up. According to information gathered</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>from the investigation with staff and consumers present during the alleged time. The allegation of verbal abuse was unsubstantiated."</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 7:00am, indicated an "Unknown origin" injury for client F. The report indicated client F was seen at the local emergency room after "complaining her wrist was hurting...a sling type wrap was applied to the right wrist and hand...DX (Diagnosis) right wrist strain, DJD (Degenerative Joint Disease), Right middle phalynx (sic) finger fracture." No cause of the injury was available for review. The follow up BDDS report indicated "the nurse noticed bruising of older colors" on client F's hand and finger. The report indicated the group home staff had signed skin checks for the previous days and no record was recorded of client F's injury or skin discoloration.</p> <p>-A 12/12/14 BDDS report for an incident reported on 12/11/14 to the administrator and occurring on 12/10/14 at 6:00pm, indicated client F reported that "she was not allowed to have coffee on the evening of 12/10/14 time is unknown." The report indicated the Residential Director (RM) on that date "gathered" information that clients B and F "was not to have coffee (sic)" and the RM "told the staff"</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>that clients B and F "was entitled to have coffee (sic)." The report indicated "additional disciplinary action will be taken due to this being the second incident of this staff withholding coffee to [clients B and F] causing behaviors of physical aggression." On 2/27/15 at 9:45am, the Chief Operations Officer (COO) indicated GHS #5 was the identified staff person involved.</p> <p>-A 12/8/14 BDDS report for an incident reported on 12/6/14 to the administrator and occurring on 12/6/14 at 6:35pm, indicated the agency's Registered Nurse (RN) "arrived" to the group home at 6:35pm to perform nursing visits. The report indicated "upon entry of the home consumers [clients A, B, C, D, E, and F] were noted to be sitting at the dining room table eating supper. [The agency RN] noted that no staff were present. When going to office to drop off materials, one staff member came out of the restroom...[The agency RN] went to look for staff and the one staff was speaking through the back door to someone." The report indicated the other staff was outside smoking. The investigation indicated clients were not eating without staff present and were seated at the dining room table. The investigation indicated the staff outside was able to see the clients at the dining</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>room table and indicated the allegation was unsubstantiated. The investigation indicated GHS #5 was the staff outside smoking during the incident. The investigation indicated clients A, B, C, D, E, and F "required 24 hour a day staff supervision. Yes it is determined that staff should have been with the consumers during meals. This will be addressed through disciplinary action including retraining of all home staff."</p> <p>On 2/25/15 at 4:15pm, an interview with the COO (Chief Operations Officer) was conducted. The COO stated clients A, B, C, D, E, and discharged client F "required" twenty-four hour a day, seven days a week staff supervision. The COO stated clients A, B, C, D, E, and F "required" and should have staff supervision while eating, cooking, pouring coffee, and living in the group home. The COO stated GHS #1 and #5 spoke with words used in the BDDS reports "during normal conversation. It's their way" of communicating. The COO indicated abuse, neglect, and/or mistreatment was not substantiated for those incidents. The COO indicated the investigations were missing listed components for the investigations and the investigations were not thorough.</p> <p>On 2/26/15 at 12:40pm, an interview</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with the COO (Chief Operations Officer) was conducted. The COO indicated the group home staff to client inappropriate interactions were investigated for each incident and staff were to have been retrained after each incident. The COO indicated the QIDP (Qualified Intellectual Disabilities Professional) was on a Leave of Absence at this time and not all trainings had been accounted for. The COO stated the report for client B on 2/26/15 should have included that GHS #5 "had removed a blanket roughly off" of client B who was asleep on the sofa in the living room at the time. The COO indicated the staff involved was immediately suspended. The COO indicated the facility staff did not protect clients A, B, C, D, E, and F from further staff abuse, neglect, and/or mistreatment when they failed to immediately report the incidents for allegations immediately to the administrator. The COO indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect/and/or mistreatment. The COO indicated when they became aware of the incident they took immediate action. The COO indicated during each incident the staff person finished their shift of work until the allegation incident was reported to the agency. The COO indicated the facility's corrective measures were not effective when the			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 157 Bldg. 00	<p>allegations and incidents continued to occur. No further information was available for review.</p> <p>On 3/6/15 at 7:35am, an interview with the COO was conducted. The COO indicated no further information was available for review.</p> <p>This federal tag relates to complaint #IN00162895.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview, for 9 of 10 allegations (for clients A, B, C, D, E, and F) reported and for 9 of 27 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed for clients A, B, C, D, E, and F to complete effective corrective action after allegations of abuse, neglect, and/or mistreatment.</p> <p>Findings include:</p> <p>On 2/25/15 from 5:15pm until 6:15pm, clients A, B, C, D, and E were observed at the group home with GHS (Group</p>	W 157	<p><b>W157 StaffTreatment of Clients</b></p> <p>This item outlines that the agency failed to complete effective corrective action after allegations of abuse, neglect and/or mistreatment were made. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>·All clients were affected by this deficient practice.</li> <li>·Management will receive mandatory training on the Investigation Process with the Corporate Compliance Officer no later than 4/5/2015.</li> </ul>	04/05/2015

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Home Staff) #3 and #5. Client F was not present at the group home. At 5:15pm, GHS #5 stated she "did take food from [client F] because she would eat too fast and would take the plate away" from client F. At 5:15pm, client C stated she "sometimes got coffee" to drink and indicated she would like to have coffee to drink. At 5:15pm, client A stated "Yes, [GHS #5] took my walker away" from me before. At 5:30pm, the current Residential Manager (RM) stated it was not part of "any" client plans to take food away from them, to remove "any" clients' plate, or to remove "any" clients' walker from the client. The RM indicated she began working as the group home RM on 2/1/15. The RM indicated she had been retraining staff to provide coffee and interactions with clients. At 5:35pm, clients B and E were non verbal and made their needs known through gestures, facial expressions, and vocalizations. At 5:35pm, clients A and D stated they would not report staff who were "mean" to them.</p> <p>On 2/25/15 at 4:15pm, and on 2/26/15 at 9:30am, the facility's BDDS Reports and investigations were reviewed from 12/2015 through 02/25/15. The review indicated the following.</p> <p>-A 2/6/15 BDDS report for an incident</p>		<ul style="list-style-type: none"> <li>·The agency'sCorporate Compliance Officer will be monitoring this process by tracking alldocumentation of all ANME investigations to assure timely and thoroughcompletion with all required components included.</li> <li>·The agency'sCorporate Compliance Officer will meet at least once per month withdirector-level management to identify any trends that may be occurring.</li> <li>·The agency'sCorporate Compliance Officer will identify staff-specific trends to identifysituations whereby repeated allegations are made toward the same employee andwill discuss this with the Chief Operations Officer, the Director of HumanResources and Staff Development and/or the Chief Executive Officer asappropriate. This monitoring will occuron an ongoing basis as allegations made and investigations are initiated.</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reported on 2/5/15 at 12:15pm. The BDDS report indicated client F "was alleging physical abuse from [GHS (Group Home Staff) #5]" and the report indicated GHS #5 was "suspended immediately." The report indicated the "Allegation was not substantiated. Investigation was completed." The report indicated client F had "hallucinations... (and) It was reported that [GHS #5] allegedly hit [client F] on her left arm while [client F] was in her chair in her bedroom. Investigation yielded that the alleged staff was not in the consumer's room." No corrective action was available for review.</p> <p>-A 1/12/15 BDDS report for an incident on 1/10/15 at 5:30pm, reported on 1/12/15 to the administrator. The report indicated "It was reported on Saturday 1/10/15 that [GHS #5] has been abusive and neglectful towards [clients A and F]. According to the report [GHS #5] will take [client F's] plate of food away from in front of her due to eating rapidly. [GHS #5] will return the food and prompt [client F] to eat slower. After the third incidents of having to remove the food away, it is reported that [GHS #5] would puree [client F's] food. [Client F] is on a mechanical soft diet with ground meats. According to the report [GHS #5] would take [client A's] rollator walker from her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>as a punishment for falling asleep in the living room after dinner. [GHS #5] would also have [client A] walk laps from one end of the house to the other end of the house without the use of the walker." The corrective action indicated GHS #5 was retrained on each clients dining plan, ISP (Individual Support Plan), and risk plans. No staff retraining for immediately reporting allegations of abuse, neglect, and/or mistreatment was available for review.</p> <p>-The 1/12/15 investigation into the incident on 1/10/15 at 5:30pm, indicated the allegation was unsubstantiated and "staff will be retrained on the dining and dysphagia management plans." The investigation included witness statements from GHS #1, GHS #3, GHS #4, and GHS #5. GHS #3 and GHS #4's witness statements indicated a new/different allegation regarding allegations of verbal abuse reported to them by GHS #2 against GHS #5. The investigation did not include witness statements from GHS #2 and/or retraining staff on immediately reporting allegations in accordance with state law.</p> <p>-A 1/12/15 BDDS report for an incident on 1/12/15 at 7:00am, indicated "It was reported that on Saturday 1/10/15 that [GHS #1] was verbally aggressive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>towards [client F] in an increased volume and by telling [client F] to shut the f--- up. According to information gathered from the investigation with staff and consumers present during the alleged time. The allegation of verbal abuse was unsubstantiated." The report indicated the corrective measure was "the policy" will be reviewed "at the staff meeting 1/16/15."</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 7:00am, indicated an "Unknown origin" injury for client F. The report indicated client F was seen at the local emergency room after "complaining her wrist was hurting...a sling type wrap was applied to the right wrist and hand...DX (Diagnosis) right wrist strain, DJD (Degenerative Joint Disease), Right middle phalynx (sic) finger fracture." No cause of the injury was available for review. The follow up BDDS report indicated "the nurse noticed bruising of older colors" on client F's hand and finger. The report indicated the group home staff had signed skin checks for the previous days and no record was recorded of client F's injury or skin discoloration. No corrective action was available for review.</p> <p>-A 12/12/14 BDDS report for an incident reported on 12/11/14 to the administrator</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and occurring on 12/10/14 at 6:00pm, indicated client F reported that "she was not allowed to have coffee on the evening of 12/10/14 time is unknown." The report indicated the Residential Director (RM) on that date "gathered" information that clients B and F "was not to have coffee (sic)" and the RM "told the staff" that clients B and F "was entitled to have coffee (sic)." The report indicated "additional disciplinary action will be taken due to this being the second incident of this staff withholding coffee to [clients B and F] causing behaviors of physical aggression." On 2/27/15 at 9:45am, the Chief Operations Officer (COO) indicated GHS #5 was the identified staff person involved. The corrective measures were completed on 12/11/14 for GHS #5 retraining on clients A, B, C, D, E, and F's ISP's, dining plans, and risk plans.</p> <p>-A 12/8/14 BDDS report for an incident reported on 12/6/14 to the administrator and occurring on 12/6/14 at 6:35pm, indicated the agency Registered Nurse (RN) "arrived" to the group home at 6:35pm to perform nursing visits. The report indicated "upon entry of the home consumers [clients A, B, C, D, E, and F] were noted to be sitting at the dining room table eating supper. [The agency RN] noted that no staff were present.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>When going to office to drop off materials, one staff member came out of the restroom...[The agency RN] went to look for staff and the one staff was speaking through the back door to someone." The report indicated the other staff was outside smoking. The investigation indicated clients were not eating without staff present and were seated at the dining room table. The investigation indicated the staff outside was able to see the clients at the dining room table and indicated the allegation was unsubstantiated. The investigation indicated GHS #5 was the staff outside smoking during the incident. The investigation indicated clients A, B, C, D, E, and F "required 24 hour a day staff supervision. Yes it is determined that staff should have been with the consumers during meals. This will be addressed through disciplinary action including retraining of all home staff." No corrective action was available for review.</p> <p>On 2/28/15 at 4:30pm, the COO provided additional BDDS reports for review of allegations of abuse, neglect, and/or mistreatment which indicated the following.</p> <p>-A 2/28/15 BDDS report for an allegation on 2/28/15 at 2:05pm, indicated "staff</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reports to [COO] that when 2nd shift reports for their shift upon entering...the second shift staff noticed that [client C] in a w/c (wheelchair) her alarm was going off and [client B] was needing assistance making coffee and staff was sitting in a chair with [GHS #1 and #4's] legs over the side of the arm (talking) on her cell phone and did not help the consumer at the needed assistance at the time (sic)." No corrective action was available for review.</p> <p>-A 2/28/15 BDDS report for an allegation on 2/28/15 at 2:05pm, indicated "received a call from staff stating that another staff was getting aggravated with some noises that [client B] was making. Staff started yelling at the client to stop making the noises...[Client B] started making the noises again. Staff then proceeded to start pushing very violently the client into the counter while seated. Then [the staff] took the client's food away from her." The report indicated staff was suspended pending investigation and "the team will monitor." No corrective action was available for review.</p> <p>On 3/4/15 at 10am, the 3/3/15 follow up BDDS report to the allegation regarding staff not supervising clients and (talking) on their cell phone was "substantiated"</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and indicated staff "will be retrained." The 3/2/15 investigation indicated GHS #5 was terminated from employment for "continued" inappropriate interactions with clients.</p> <p>On 2/25/15 at 4:15pm, an interview with the COO (Chief Operations Officer) was conducted. The COO stated clients A, B, C, D, E, and discharged client F "required" twenty-four hour a day, seven days a week staff supervision. The COO stated clients A, B, C, D, E, and F "required" and should have staff supervision while eating, cooking, pouring coffee, and living in the group home.</p> <p>On 2/26/15 at 12:40pm, an interview with the COO (Chief Operations Officer) was conducted. The COO indicated the group home staff to client inappropriate interactions were investigated for each incident and staff were to have been retrained after each incident. The COO indicated the QIDP (Qualified Intellectual Disabilities Professional) was on a Leave of Absence at this time and not all trainings had been accounted for. The COO stated the report for client B on 2/26/15 should have included that GHS #5 "had removed a blanket roughly off" of client B who was asleep on the sofa in the living room at the time. The COO</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the staff involved was immediately suspended. The COO indicated the facility staff did not protect clients A, B, C, D, E, and F from further staff abuse, neglect, and/or mistreatment when they failed to immediately report the incidents for allegations immediately to the administrator. The COO indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect/and/or mistreatment. The COO indicated when they became aware of the incident they took immediate action. The COO indicated during each incident the staff person finished their shift of work until the allegation incident was reported to the agency. The COO indicated the facility's corrective measures were not effective when the allegations and incidents continued to occur. No further information was available for review.</p> <p>On 3/6/15 at 7:35am, an interview with the COO was conducted. The COO indicated no further information was available for review.</p> <p>This federal tag relates to complaint #IN00162895.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 249  Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and F) and 3 additional clients (clients C, D, and E), for 9 of 10 allegations (for clients A, B, C, D, E, and F) reported and for 9 of 27 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to ensure staff were available and supervised clients at the group home according to their identified training needs.</p> <p>Findings include:</p> <p>On 2/25/15 from 5:15pm until 6:15pm, clients A, B, C, D, and E were observed at the group home with GHS (Group Home Staff) #3 and #5. Client F was not present at the group home. At 5:15pm, GHS #5 stated she "did take food from [client F] because she would eat too fast and would take the plate away" from client F. At 5:15pm, client C stated she "sometimes got coffee" to drink and indicated she would like to have coffee to</p>	W 249	<p><b>W249</b> <b>ProgramImplementation</b></p> <p>This item outlines that the agency failed to ensure staff were available and supervised clients at the group home according to their identified training needs. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>·All clients were affected by this deficiency.</li> <li>·Mandatory Training on Abuse, Neglect, Mistreatment and Exploitation and Timing of such reportable incidents will occur no later than 4/5/2015 with all staff.</li> <li>·Mandatory Training on ISPs, Risk Plans and BSPs will occur with all staff no later than 4/5/2015.</li> <li>·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</li> </ul>	04/05/2015
-----------------------	---	-------	---	------------

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  03/06/2015
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>drink. At 5:15pm, client A stated "Yes, [GHS #5] took my walker away" from me before. At 5:30pm, the current Residential Manager (RM) stated it was not part of "any" client plans to take food away from them, to remove "any" clients' plate, or to remove "any" clients' walker from the client. The RM indicated she began working as the group home RM on 2/1/15. The RM indicated she had been retraining staff to provide coffee and interactions with clients. At 5:35pm, clients B and E were non verbal and made their needs known through gestures, facial expressions, and vocalizations. At 5:35pm, clients A and D stated they would not report staff who were mean to them.</p> <p>On 2/25/15 at 4:15pm, and on 2/26/15 at 9:30am, the facility's BDDS Reports and investigations were reviewed from 12/2015 through 02/25/15. The review indicated the following.</p> <p>-A 2/6/15 BDDS report for an incident reported on 2/5/15 at 12:15pm. The BDDS report indicated client F "was alleging physical abuse from [GHS (Group Home Staff) #5]" and the report indicated GHS #5 was "suspended immediately." The report indicated the "Allegation was not substantiated. Investigation was completed." The report</p>		<p>incidents. The manager will track all staff who attend these mandatory meetings and keep documentation in the manager's workingfiles. 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 monitoring agent will be the manager of the home will document observations for at least 5 days out of every 7 per week. The frequency will increase if any ANME incidents are noted or found during the intensive observation period. The manager will document observation on a "Group Home Observation" form and will submit this to the Director of Group Homes or to the Chief Operations Officer if the Director of Group Homes is a vacant position or is not available. These observations will occur at this frequency for at least one month. At that time, the manager and the Director of Group Homes (or the Chief Operations Officer) will re-evaluate the frequency and determine if less frequent documented observations is appropriate.</p> <p>The manager will interview clients, at least one client per day in which an observation occurs (as described above). To assure that</p>		

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  03/06/2015
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated client F had "hallucinations... (and) It was reported that [GHS #5] allegedly hit [client F] on her left arm while [client F] was in her chair in her bedroom. Investigation yielded that the alleged staff was not in the consumer's room."</p> <p>-A 1/12/15 BDDS report for an incident on 1/10/15 at 5:30pm, reported on 1/12/15 to the administrator. The report indicated "It was reported on Saturday 1/10/15 that [GHS #5] has been abusive and neglectful towards [clients A and F]. According to the report [GHS #5] will take [client F's] plate of food away from in front of her due to eating rapidly. [GHS #5] will return the food and prompt [client F] to eat slower. After the third incidents of having to remove the food away, it is reported that [GHS #5] would puree [client F's] food. [Client F] is on a mechanical soft diet with ground meats. According to the report [GHS #5] would take [client A's] rollator walker from her as a punishment for falling asleep in the living room after dinner. [GHS #5] would also have [client A] walk laps from one end of the house to the other end of the house without the use of the walker."</p> <p>-The 1/12/15 investigation into the incident on 1/10/15 at 5:30pm, indicated</p>		<p>the client feels that he/she is safe,secure, and free of abuse, neglect, mistreatment or exploitation. These interviews will be documented and willbe submitted to the Director of Group Homes or the Chief Operations Officer inthe Director's absence. These documentedinterviews will occur at this frequency for at least one month. At that time, the manager and the Director ofGroup Homes (or the Chief Operations Officer) will re-evaluate the frequencyand determine if less frequent documented observations is appropriate.</p> <p>-The manager willinitiate interviews with all staff and will include direct questioning aboutobserving any Abuse, Neglect, Mistreatment or Exploitation. The manager will meet with each staff personat least once per month to assure any issue was reported per policy, procedureand state law requires. These interviewswill be documented on a form entitled "Reflection Session" and will be submittedto the Director of Group Homes or the Chief Operations Officer in the Director'sabsence. These interviews at thisfrequency will occur indefinitely.</p> <p>-The Director ofGroup Homes and/or Chief Operations Officer will review all submitteddocumentation from the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2015
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the allegation was unsubstantiated and "staff will be retrained on the dining and dysphagia management plans." The investigation included witness statements from GHS #1, GHS #3, GHS #4, and GHS #5. GHS #3 and GHS #4's witness statements indicated a new/different allegation regarding allegations of verbal abuse reported to them by GHS #2 against GHS #5. The investigation did not include witness statements from GHS #2 and/or retraining staff on immediately reporting allegations in accordance with state law.</p> <p>-A 1/12/15 BDDS report for an incident on 1/12/15 at 7:00am, indicated "It was reported that on Saturday 1/10/15 that [GHS #1] was verbally aggressive towards [client F] in an increased volume and by telling [client F] to shut the f--- up. According to information gathered from the investigation with staff and consumers present during the alleged time. The allegation of verbal abuse was unsubstantiated." The report indicated the corrective measure was "the policy" will be reviewed "at the staff meeting 1/16/15."</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 7:00am, indicated an "Unknown origin" injury for client F. The report indicated client F was seen at the local</p>		<p>manager's interviews (staff and consumer interviews) aswell 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.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>emergency room after "complaining her wrist was hurting...a sling type wrap was applied to the right wrist and hand...DX (Diagnosis) right wrist strain, DJD (Degenerative Joint Disease), Right middle phalynx finger fracture." No cause of the injury was available for review. The follow up BDDS report indicated "the nurse noticed bruising of older colors" on client F's hand and finger. The report indicated the group home staff had signed skin checks for the previous days and no record was recorded of client F's injury or skin discoloration.</p> <p>-A 12/12/14 BDDS report for an incident reported on 12/11/14 to the administrator and occurring on 12/10/14 at 6:00pm, indicated client F reported that "she was not allowed to have coffee on the evening of 12/10/14 time is unknown." The report indicated the Residential Director (RM) on that date "gathered" information that clients B and F "was not to have coffee (sic)" and the RM "told the staff" that clients B and F "was entitled to have coffee (sic)." The report indicated "additional disciplinary action will be taken due to this being the second incident of this staff withholding coffee to [clients B and F] causing behaviors of physical aggression." On 2/27/15 at 9:45am, the Chief Operations Officer (COO) indicated GHS #5 was the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2015	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>identified staff person involved.</p> <p>-A 12/8/14 BDDS report for an incident reported on 12/6/14 to the administrator and occurring on 12/6/14 at 6:35pm, indicated the agency Registered Nurse (RN) "arrived" to the group home at 6:35pm to perform nursing visits. The report indicated "upon entry of the home consumers [clients A, B, C, D, E, and F] were noted to be sitting at the dining room table eating supper. [The agency RN] noted that no staff were present. When going to office to drop off materials, one staff member came out of the restroom...[The agency RN] went to look for staff and the one staff was speaking through the back door to someone." The report indicated the other staff was outside smoking. The investigation indicated clients were not eating without staff present and were seated at the dining room table. The investigation indicated the staff outside was able to see the clients at the dining room table and indicated the allegation was unsubstantiated. The investigation indicated GHS #5 was the staff outside smoking during the incident. The investigation indicated clients A, B, C, D, E, and F "required 24 hour a day staff supervision. Yes it is determined that staff should have been with the consumers during meals. This will be</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>addressed through disciplinary action including retraining of all home staff." No corrective action was available for review.</p> <p>On 2/28/15 at 4:30pm, the COO provided additional BDDS reports for review of allegations of abuse, neglect, and/or mistreatment which indicated the following.</p> <p>-A 2/28/15 BDDS report for an allegation on 2/28/15 at 2:05pm, indicated "staff reports to [COO] that when 2nd shift reports for their shift upon entering...the second shift staff noticed that [client C] in a w/c (wheelchair) her alarm was going off and [client B] was needing assistance making coffee and staff was sitting in a chair with [GHS #1 and #4's] legs over the side of the arm (talking) on her cell phone and did not help the consumer at the needed assistance at the time (sic)."</p> <p>-A 2/28/15 BDDS report for an allegation on 2/28/15 at 2:05pm, indicated "received a call from staff stating that another staff was getting aggravated with some noises that [client B] was making. Staff started yelling at the client to stop making the noises...[Client B] started making the noises again. Staff then proceeded to start pushing very violently</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the client into the counter while seated. Then [the staff] took the client's food away from her." The report indicated staff was suspended pending investigation and "the team will monitor."</p> <p>On 3/4/15 at 10am, the 3/3/15 follow up BDDS report to the allegation regarding staff not supervising clients and (talking) on their cell phone was "substantiated" and indicated staff "will be retrained." The 3/2/15 investigation indicated GHS #5 was terminated from employment for "continued" inappropriate interactions with clients.</p> <p>On 2/25/15 at 4:15pm, an interview with the COO (Chief Operations Officer) was conducted. The COO stated clients A, B, C, D, E, and discharged client F "required" twenty-four hour a day, seven days a week staff supervision. The COO stated clients A, B, C, D, E, and F "required" and should have staff supervision while eating, cooking, pouring coffee, and living in the group home. The COO indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations.</p> <p>On 2/26/15 at 12:40pm, an interview with the COO (Chief Operations Officer) was conducted. The COO indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>group home staff to client inappropriate interactions were investigated for each incident and staff were to have been retrained after each incident. The COO indicated the QIDP (Qualified Intellectual Disabilities Professional) was on a Leave of Absence at this time and not all trainings had been accounted for. The COO stated the report for client B on 2/26/15 should have included that GHS #5 "had removed a blanket roughly off" of client B who was asleep on the sofa in the living room at the time. The COO indicated the staff involved was immediately suspended. The COO indicated the facility staff did not protect clients A, B, C, D, E, and F from further staff abuse, neglect, and/or mistreatment when they failed to immediately report the incidents for allegations immediately to the administrator. The COO indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect/and/or mistreatment. The COO indicated when they became aware of the incident they took immediate action. The COO indicated during each incident the staff person finished their shift of work until the allegation incident was reported to the agency. The COO indicated the facility's corrective measures were not effective when the allegations and incidents continued to occur. No further information was</p>			

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  03/06/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>available for review.</p> <p>On 3/6/15 at 7:35am, an interview with the COO was conducted. The COO indicated no further information was available for review.</p> <p>Client A's record was reviewed on 2/25/15 at 12:58pm. Client A's 10/14/14 ISP (Individual Support Plan) indicated client A required staff supervision twenty-four hours a day/seven days per week. Client A's ISP indicated she used a roller walker for her mobility. Client A's ISP indicated client A was on a pureed diet with thickened liquids because of her choking risk. Client A's 1/15/15 Dining Plan indicated "Staff (should be) seated at eye level during dining" for monitoring and to assist client A. Client A's record did not include the restriction of drinking coffee as desired.</p> <p>Client B's record was reviewed on 3/2/15 at 2:30pm. Client B's 4/18/14 ISP indicated client B required staff supervision twenty-four hours a day/seven days per week and client B was non verbal. Client B's ISP indicated she communicated with "gestures and guttural noises." Client B's ISP indicated client B was on a regular diet. Client B's 12/2013 Dining Plan indicated staff should supervise client B during dining</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and prompt her to drink between bites of food. Client B's record did not include the restriction from drinking coffee as desired.</p> <p>Client F's record was reviewed on 2/25/15 at 1:50pm. Client F's 5/20/14 ISP indicated client F required staff supervision twenty-four hours a day/seven days per week. Client F's ISP indicated she used a roller walker for her mobility. Client F's ISP indicated client F was on a mechanical soft diet and her food was to be cut up into bite size portions. Client F's record indicated she was discharged to a nursing home because of her medical needs on 2/12/15.</p> <p>This federal tag relates to complaint #IN00162895.</p> <p>9-3-2(a)</p>			