

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2015
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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 11/17, 11/18, 11/19, 11/20, and 11/23/15.</p> <p>Provider Number: 15G581 AIM Number: 100245560 Facility Number: 001095</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/8/15.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home.</p> <p>Findings include:</p>	W 0104	<p>W104 – “ The governing body must exercise general policy, budget, and operating direction over the facility” The governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home. The plan of correction for this tag is as follows: ·The shower curtain in the men’s restroom was replaced on 11/27/2015.</p>	12/23/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>During observations on 11/17/15 from 2:55pm until 6:00pm and on 11/18/15 from 6:05am until 8:05am, the following maintenance and repairs at clients #1, #2, #3, #4, #5, #6, and #7's group home were identified. On 11/17/15 at 3:15pm, the Residential Manager (RM) indicated the group home was in need of repairs. At 3:15pm, the RM indicated the mens bathroom did not have a shower curtain to enable staff to assist clients to shower.</p> <p>-The mens side bathroom shower curtain was missing. -The mens side bathroom door casing was not secured/sealed in place to secure the entry door. -Two of Three (2 of 3) mens side bathroom walls had black marks and discolorations. -The kitchen counter near the trash storage cabinet was stained and had missing pieces of counter top. -One of two (1 of 2) dining room walls had a fifteen feet long by two feet high (15' x 2') section with gouges into the dry wall and black marks.</p> <p>On 11/19/15 at 9:55am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients #1, #2, #3, #4, #5, #6, and #7's group home was in the process of being repaired. The QIDP</p>		<p>·The men's bathroom door casing was not secured/sealed in place to secure the entry door. Repairs will be made by maintenance by 12/23/2015.</p> <p>·The Director of Group Homes/ QDDP will ensure that repairs are made no later than 12/23/2015.</p> <p>·Two of three men's restroom walls had black marks and discolorations. Walls will be repaired by 12/23/2015.</p> <p>·The Director of Group Homes/ QDDP will ensure that repairs are made no later than 12/23/2015.</p> <p>·The kitchen counter near the trash storage cabinet was stained and had missing pieces of counter top. Countertop was replaced by maintenance on 12/15/2015.</p> <p>·One of the dining room walls had a section with gouges into the drywall and black marks. Repairs will be started made by maintenance by 12/23/2015.</p> <p>·The Director of Group Homes/ QDDP will ensure that repairs are started no later than 12/23/2015.</p>		

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W 0137 Bldg. 00	<p>indicated no further information was available for review.</p> <p>9-3-1(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview, and record review, for 3 of 4 sampled clients (clients #2, #3, and #4) and 2 additional clients (clients #5 and #7), the facility failed to ensure clients #2, #3, #4, #5, and #7 had unimpeded access to their locked prescribed eye glasses.</p> <p>Findings include:</p> <p>On 11/17/15 from 2:55pm until 6:00pm and on 11/18/15 from 6:05am until 8:05am, clients #2, #3, #4, #5, and #7 were observed at the group home. On 11/17/15 from 2:55pm until 4:40pm and on 11/18/15 from 6:05am until 8:05am, clients #2, #3, #4, #5, and #7 did not wear their prescribed eye glasses. On 11/17/15 at 4:40pm, GHS (Group Home Staff) #4 retrieved clients #2, #3, #4, #5, and #7's prescribed eye glasses from the locked bottom drawer in the medication cart. GHS #4 indicated no clients had</p>			W 0137	<p>W137 – “The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing”</p> <p>The facility failed to ensure clients #2, #3, #4, #5, and #7 had unimpeded access to their locked prescribed eye glasses. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Clients' #2, #3, #4, #5, and #7 eyeglasses have been moved to a new location where consumers have unimpeded access to them on 11/27/2015. 		11/27/2015

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	<p>keys to access their prescribed eye glasses secured inside the medication cart. At 4:40pm, the Residential Manager (RM) indicated she did not know why the clients' eye glasses were kept locked.</p> <p>Client #2's record was reviewed on 11/18/15 at 11:35am. Client #2's 8/7/15 ISP (Individual Support Plan) indicated she wore prescribed eye glasses. Client #2's record did not indicate an identified need for locked personal eye glasses.</p> <p>Client #3's record was reviewed on 11/18/15 at 12:10pm. Client #3's 8/7/15 ISP (Individual Support Plan) indicated she wore prescribed eye glasses. Client #3's record did not indicate an identified need for locked personal eye glasses.</p> <p>Client #4's record was reviewed on 11/18/15 at 10:15am. Client #4's 8/7/15 ISP (Individual Support Plan) indicated she wore prescribed eye glasses. Client #4's record did not indicate an identified need for locked personal eye glasses.</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse) was conducted. The QIDP and the LPN both indicated clients #2, #3, #4, #5, and #7</p>				

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W 0140 Bldg. 00	<p>should have had access to their prescribed eye glasses. The QIDP indicated clients #2, #3, #4, #5, and #7 had not been assessed as needing the restriction for locked personal prescribed eye glasses.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, for 3 of 4 sampled clients (clients #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to implement its written policy in regard to client finances to ensure accountability of clients #2, #3, #4, #5, #6, and #7's funds.</p> <p>Findings include:</p> <p>On 11/17/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and included the following incidents of missing unaccountable funds for clients #2, #3, #4, #5, #6, and #7:</p> <p>-An 11/6/15 BDDS report for an incident</p>	W 0140	<p>W140 – “The facility must establish and maintain a system that assures a full and complete accounting of clients’ personal funds entrusted to the facility on behalf of the clients”</p> <p>The facility failed to implement its written policy in regard to client finances to ensure accountability of clients #2, #3, #4, #5, #6, and #7’s funds. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> Managers are now required to keep their own record of cash funds as of 11/27/2015. The Director of Group Homes will complete random checks of these cash records to ensure that consumer funds are accounted for. 	11/27/2015	

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	<p>on 10/13/15 at 2:45pm indicated "It was found while doing financials that the following consumers were missing money. [Client #2] \$1.06, [Client #3] \$120.00, [client #4] \$0.49, [client #5] \$3.63, [client #7] \$125.48. The manager was already suspended at the time of the incident on an unrelated matter, and her employment was terminated." The report indicated "all missing funds have been reimbursed to the consumers."</p> <p>-A 5/13/15 BDDS report for an incident for clients #2, #5, #6 and two other unidentified clients living in the group home on 5/11/15 at 5:00pm indicated "It was brought to the group home manager's attention through monthly audit that monies were missing from five consumers listed in this report." The report did not include the names of the clients. The report indicated "All staff is (sic) going to be interviewed there is not a specific time frame in which this occurred we believe it happened within the month of April, but cannot pin point the exact date (sic)." The BDDS Follow up report indicated "there is no way to determine who stole the money" and the police have been notified. No amounts of the missing funds were available for review.</p> <p>On 11/17/15 at 3:05pm, the facility's</p>						

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W 0149	<p>8/15/14 "Fiscal Management Policy: Management of Consumer Funds" policy and procedure indicated "Consumer funds will be managed via approved procedures which maintain individual consumer rights through consumer informed consent. Carey Services will adequately safeguard consumer's assets through proper internal accounting practices."</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse) was conducted. The QIDP indicated the facility staff failed to ensure an accurate and complete accounting of client funds. The QIDP indicated there were missing funds during 5/2015 and again on 10/13/15 after agency audits of clients' funds. The QIDP indicated the agency had changed the procedure after the 5/2015 missing funds to secure client funds with the Residential Manager having the access to authorize and provide oversight of the funds. The QIDP indicated no further information was available for review.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p>				

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Bldg. 00	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility neglected to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law, to ensure client #6 was supervised by facility staff, and to ensure a full and accurate accounting of clients' funds.</p> <p>Findings include:</p> <p>On 11/17/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and included the following incidents:</p> <p>1. For late reporting of missing unaccountable funds for clients #2, #3, #4, #5, #6, and #7: -An 11/6/15 BDDS report for an incident on 10/13/15 at 2:45pm indicated "It was found while doing financials that the following consumers were missing money. [Client #2] \$1.06, [Client #3]</p>	W 0149	<p>W149 – “The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client”</p> <p>The facility neglected to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law to ensure Client #6 was supervised by facility staff, and to ensure a full and accurate accounting of clients' funds. The correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Mandatory retraining on Policy and Procedures with regard to reporting regulations occurred with all applicable staff by the manager of the home on 12/15/2015. ·DDRS Incident Reporting Regulations ·Carey Policy 5.13 on reporting Abuse, Neglect and Exploitation ·Carey Procedure 5.13.1 on reporting Abuse, Neglect and other reportable or unusual incidents ·Carey Policy 5.14 Staff Conduct Towards Consumers ·Carey Policy 1.3 Ethical Codes of Conduct Staff training will stress the 	12/15/2015			

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	<p>\$120.00, [client #4] \$0.49, [client #5] \$3.63, [client #7] \$125.48. The manager was already suspended at the time of the incident on an unrelated matter, and her employment was terminated." The report indicated "all missing funds have been reimbursed to the consumers."</p> <p>-A 5/13/15 BDDS report for an incident for clients #2, #5, #6 and two other unidentified clients living in the group home on 5/11/15 at 5:00pm indicated "It was brought to the group home manager's attention through monthly audit that monies were missing from five consumers listed in this report." The report did not include the names of the clients. The report indicated "All staff is (sic) going to be interviewed there is not a specific time frame in which this occurred we believe it happened within the month of April, but cannot pin point the exact date (sic)." The BDDS Follow up report indicated "there is no way to determine who stole the money" and the police have been notified. No amounts of missing funds were available for review.</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse) was conducted. The QIDP indicated the facility followed the BDDS policy and</p>		<p>importance that all staff knows it is the responsibility of each person to report suspected instances of abuse, neglect and exploitation immediately and that the facility Administrator/Administrator on Duty (AOD) and BDDS must also be notified. The manager will be responsible for assuring that the reporting regulations, policies and procedures are followed.</p> <p>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 attends these mandatory meetings and keep documentation in the manager's working files. The manager is responsible for addressing any staff person who could not attend the mandatory meeting to assure he/she receives the information covered including this standing agenda item.</p> <p>The Director of Group Homes and/or Chief Operations Officer will review all submitted documentation, BDDS reports, as well as any documentation from Group Home Observations to identify any issues or concerns as related to the topics of reporting ANME or acts of ANME.</p> <p>Managers are now required to keep their own record of cash funds. The Director of Group</p>				

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	<p>procedure for allegations of abuse, neglect, and/or mistreatment. The QIDP indicated the facility staff neglected to immediately report and to ensure an accurate and complete accounting of client funds. The QIDP indicated there were missing funds during 5/2015 and again on 10/13/15 after agency audits of clients' funds. The QIDP indicated no further information was available for review.</p> <p>2. For late reporting of client #6's AWOL (Absent Without Leave) incident and substantiated staff neglect: -A 6/17/15 BDDS report for an incident on 6/16/15 at 4:15pm indicated client #6 "was found off the property of the group home by the group home manager. The approximate time of AWOL was 5-15 minutes. Staff was following the current BSP (Behavior Support Plan) which allows [Client #6] to be outside with checks on him through the window." -A 6/19/15 BDDS Follow up report indicated "Staff was unaware that [client #6] was not in the yard...Staff was not following appropriate level of supervision as listed in [client #6's] BSP. The result of the investigation is that the neglect is substantiated due to the length of time the staff was unaware that the client had left the porch."</p>		Homes will complete random checks of these cash records to ensure that consumer funds are accounted for.				

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	<p>The 6/17/15 "Investigation" into client #6's 6/16/15 AWOL incident indicated "During a phone call [name of a different Residential Manager] it was reported that [client #6] had been found down the road from the group home...The [Residential Manager from client #6's group home] who was with the [name of other Residential Manager] had [client #6] get into the vehicle and brought him to the agency. [Client #6's Residential Manager] did not inform staff of this...Summary...The allegation of neglect was substantiated."</p> <p>On 11/19/15 at 9:55am, an interview was conducted with the QIDP. The QIDP indicated client #6 did not have independent community safety skills and staff were to have watched client #6 through the window when client #6 was outside on the porch. The QIDP indicated the Residential Manager neglected to immediately report client #6's AWOL and the incident was reported by a different Residential Manager.</p> <p>3. For substantiated staff to client abuse and the failure to immediately report allegations of abuse, neglect, and/or mistreatment for clients #1, #2, #3, #4, #5, #6, and #7:</p>			

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	<p>-A 12/19/14 BDDS report for an incident on 12/10/14 at 1:30pm, indicated "Alleged abuse, emotional /verbal...Narrative: During discussion with group home staff (at a house meeting) the [Names of QIDP (Qualified Intellectual Disabilities Professional) and Residential Manager] were informed of possible verbal and physical allegations of abuse by one staff member." The staff member was contacted and suspended.</p> <p>The 12/11/14 "Investigation" indicated "Allegation of pattern of physical, verbal, and emotional abuse by staff over time...During investigation of [Discharged Staff #11] regarding insubordination and threatening co-workers (sic) several allegations of physical, verbal, and emotional abuse towards clients by [Discharged Staff #11] were made during staff interviews resulting in the full investigation...." The staff interviewed reported the following regarding abuse, neglect, and mistreatment by Discharged Staff #11: -"Often takes things away from [client #5] in order to get her to mind." -"He will kick consumer's chairs to get them to mind or to get their attention." -"Sometimes staff would ask consumers if they needed to get [name of Discharged Staff #11] to get them to mind." -Discharged Staff #11 was "yelling at"</p>			

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	<p>client #5 or other "consumers to get them to mind."</p> <p>-"Saw [Discharged Staff #11] tell [client #2] to mover (sic) her big butt over when putting consumers in the van."</p> <p>-"Uses a harsh tone (of voice) with consumers."</p> <p>-"Witnessed [Discharged Staff #11] place his hand on consumers and push their head back to give medications. Has seen him kick [a discharged client's] chair around at the table to get a client up. Has seen him push [client #3's] head down to get her to eat. Also witnesses him taking [client #2's] purse away from her."</p> <p>-"He will tap forcefully upside [client #3's] head to get her to move...Smack a client's hand if reaching for something...he often takes things from consumers like [client #5's] purse or hat and it will sometimes lead to a behavior."</p> <p>-"Calls clients" profane names.</p> <p>-He "will take [client #5's] teddy bear from her and go in the office and close the door. Recalls one time when [client #5] was pounding the door nearly crying, [Discharged Staff #11] opened it and told [client #5] to leave him alone and her teddy bear was gone and then shut the door back in her face."</p> <p>-The agency LPN (Licensed Practical Nurse) "witnessed [Discharged Staff #11] refer to consumers as dorky and tell them to shut up or to go to your room. [The</p>			

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953
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	<p>LPN] believes he thinks he is joking."</p> <p>The investigation indicated "The allegations of verbal and physical abuse towards consumers based on a preponderance of the eye witness testimony as well as his own testimony are substantiated. Additionally there is significant reason to believe that [Discharged Staff #11] has engaged in a pattern of intimidation with both consumers and staff over a period of months." Staff were instructed on the importance of reporting allegations and the staff member was terminated.</p> <p>On 11/17/15 at 1:30pm, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the</p>			

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	<p>individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 11/17/15 at 1:30pm, the facility's records were reviewed. A review of the facility's 6/15/11 policy on "Abuse, Neglect, and Exploitation" indicated, "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible abusive treatment, negligence, or exploitation on the part of staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency....Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and equipment (as indicated in the ISP (Individual Support Plan)." The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law.</p>			

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	<p>On 11/17/15 at 1:30pm, the facility's 6/2011 "Procedures for Reporting abuse, neglect, and other Reportable or Unusual Incidents" indicated "As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and exploitation...Staff and volunteers are provided training and/or tested for competency on an annual basis regarding their responsibilities in reporting such incidents to authorities as well as to agency's administrators immediately upon learning of the suspected abuse/neglect/exploitation." The policy indicated reportable incidents are "1. Any alleged, suspected, or actual abuse, neglect, or exploitation of a consumer."</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse) was conducted. The QIDP indicated the agency investigated allegations by staff of staff to client abuse, neglect, and/or mistreatment. The QIDP indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The QIDP indicated the facility staff neglected to immediately report allegations of suspected abuse, neglect, and/or mistreatment. The QIDP indicated the</p>			

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W 0153 Bldg. 00	<p>facility staff neglected to ensure an accurate and complete accounting for client funds. The QIDP indicated there were missing funds during 5/2015 and again on 10/13/15 after agency audits of clients' funds.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>Based on record review and interview, for 2 of 51 incident reports reviewed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p> <p>On 11/17/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and included the following incidents:</p>	W 0153	<p>W153 – “The facility must ensure that allallegations of mistreatment, neglect or abuse, as well as injuries of unknownsource are reported immediately to the administrator or to other officials inaccordance with state law through established procedures”</p> <p>The facility failed toimmediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of DevelopmentalDisabilities Services) in accordance with state law. The plan of correction forthis tag is as follows:</p> <ul style="list-style-type: none"> ·Mandatory retraining on Policy and Procedures with regard to 	12/15/2015

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953		
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	<p>1. Failed to immediately report client #6's AWOL (Absent Without Leave) incident and substantiated staff neglect: -A 6/17/15 BDDS report for an incident on 6/16/15 at 4:15pm indicated client #6 "was found off the property of the group home by the group home manager. The approximate time of AWOL was 5-15 minutes. Staff was following the current BSP (Behavior Support Plan) which allows [Client #6] to be outside with checks on him through the window."</p> <p>-A 6/19/15 BDDS Follow up report indicated "Staff was unaware that [client #6] was not in the yard...Staff was not following appropriate level of supervision as listed in [client #6's] BSP. The result of the investigation is that the neglect is substantiated due to the length of time the staff was unaware that the client had left the porch."</p> <p>The 6/17/15 "Investigation" into client #6's 6/16/15 AWOL incident indicated "During a phone call [name of a different Residential Manager] it was reported that [client #6] had been found down the road from the group home...The [Residential Manager from client #6's group home] who was with the [name of other Residential Manager] had [client #6] get into the vehicle and brought him to the</p>		<p>reporting regulations occurred with all applicable staff by the manager of the home on 12/15/2015.</p> <ul style="list-style-type: none"> ·DDRS Incident Reporting Regulations ·Carey Policy 5.13 on reporting Abuse, Neglect and Exploitation ·Carey Procedure 5.13.1 on reporting Abuse, Neglect and other reportable or unusual incidents ·Carey Policy 5.14 Staff Conduct Towards Consumers ·Carey Policy 1.3 Ethical Codes of Conduct <p>Staff training will stress the importance that all staff knows it is the responsibility of each person to report suspected instances of abuse, neglect and exploitation immediately and that the facility Administrator/Administrator on Duty (AOD) and BDDS must also be notified. The manager will be responsible for assuring that the reporting regulations, policies and procedures are followed.</p> <ul style="list-style-type: none"> ·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 attends these mandatory meetings and keep documentation in the manager's working files. The manager is 		

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	<p>agency. [Client #6's Residential Manager] did not inform staff of this...Summary...The allegation of neglect was substantiated."</p> <p>On 11/19/15 at 9:55am, an interview was conducted with the QIDP. The QIDP indicated client #6 did not have independent community safety skills and staff were to have watched client #6 through the window when client #6 was outside on the porch. The QIDP indicated the Residential Manager neglected to immediately report client #6's AWOL and the incident was reported by a different Residential Manager.</p> <p>2. Failed to immediately report allegations of substantiated staff to client abuse, neglect, and/or mistreatment for clients #1, #2, #3, #4, #5, #6, and #7: -A 12/19/14 BDDS report for an incident on 12/10/14 at 1:30pm, indicated "Alleged abuse, emotional /verbal...Narrative: During discussion with group home staff (at a house meeting) the [Names of QIDP (Qualified Intellectual Disabilities Professional) and Residential Manager] were informed of possible verbal and physical allegations of abuse by one staff member." The staff member was contacted and suspended.</p>		<p>responsible for addressing any staff person who could not attend the mandatory meeting to assure he/she receives the information covered including this standing agenda item.</p> <p>·The Director of Group Homes and/or Chief Operations Officer will review all submitted documentation, BDDS reports, as well as any documentation from Group Home Observations to identify any issues or concerns as related to the topics of reporting ANME or acts of ANME.</p>		

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	<p>The 12/11/14 "Investigation" indicated "Allegation of pattern of physical, verbal, and emotional abuse by staff over time...During investigation of [Discharged Staff #11] regarding insubordination and threatening co-workers (sic) several allegations of physical, verbal, and emotional abuse towards clients by [Discharged Staff #11] were made during staff interviews resulting in the full investigation...." The staff interviewed reported the following regarding abuse, neglect, and mistreatment by Discharged Staff #11:</p> <ul style="list-style-type: none"> - "Often takes things away from [client #5] in order to get her to mind." - "He will kick consumer's chairs to get them to mind or to get their attention." - "Sometimes staff would ask consumers if they needed to get [name of Discharged Staff #11] to get them to mind." - Discharged Staff #11 was "yelling at" client #5 or other "consumers to get them to mind." - "Saw [Discharged Staff #11] tell [client #2] to mover (sic) her big butt over when putting consumers in the van." - "Uses a harsh tone (of voice) with consumers." - "Witnessed [Discharged Staff #11] place his hand on consumers and push their head back to give medications. Has seen him kick [a discharged client's] chair around at the table to get a client up. Has 			

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	<p>seen him push [client #3's] head down to get her to eat. Also witnesses him taking [client #2's] purse away from her." -"He will tap forcefully upside [client #3's] head to get her to move...Smack a client's hand if reaching for something...he often takes things from consumers like [client #5's] purse or hat and it will sometimes lead to a behavior." -"Calls clients" profane names. -He "will take [client #5's] teddy bear from her and go in the office and close the door. Recalls one time when [client #5] was pounding the door nearly crying, [Discharged Staff #11] opened it and told [client #5] to leave him alone and her teddy bear was gone and then shut the door back in her face." -The agency LPN (Licensed Practical Nurse) "witnessed [Discharged Staff #11] refer to consumers as dorky and tell them to shut up or to go to your room. [The LPN] believes he thinks he is joking."</p> <p>The investigation indicated "The allegations of verbal and physical abuse towards consumers based on a preponderance of the eye witness testimony as well as his own testimony are substantiated. Additionally there is significant reason to believe that [Discharged Staff #11] has engaged in a pattern of intimidation with both consumers and staff over a period of</p>				

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W 0247 Bldg. 00	<p>months." Staff were instructed on the importance of reporting allegations and the staff member was terminated.</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse) was conducted. The QIDP indicated the facility staff failed to immediately report allegations of suspected abuse, neglect, and/or mistreatment and staff supervision of client #6 to the administrator and to BDDS in accordance with State Law. The QIDP indicated no further information was available for review.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 3 additional clients (clients #5, #6, and #7), the facility failed to encourage choice of the facility's afternoon snack and beverages.</p> <p>Findings include:</p>	W 0247	<p>W247 – “The individual program plan must include opportunities for client choice and self-management”</p> <p>The facility failed to encourage choice of the facility's afternoon snack and beverages. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Staff has been retrained on client choice and active treatment on 12/15/2015. 	12/15/2015			

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953			
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	<p>On 11/17/15 from 2:55pm until 6:00pm, observations were conducted at clients #1, #2, #3, #4, #5, #6, and #7's group home. On 11/17/15 at 3:30pm, GHS (Group Home Staff) #4 selected and prepared graham crackers in a bowl and set the bowl on the dining room table. GHS #4 asked client #2 if she wanted the prepared snack of graham crackers soaked in milk. Client #2 consumed the snack. At 3:30pm, client #4 requested Ice Tea to drink with her snack. GHS #4 offered client #2 Lemonade. Client #4 requested Ice Tea a second time. GHS #4 indicated there was no Ice Tea mix available and GHS #2 retrieved a glass, mixed water to a honey consistency, and gave the glass of water to client #2. At 4:40pm, client #3 was prompted to the dining room table, where GHS #1 and GHS #2 had placed a single dish with four (4) Cheese and Cracker snack, and prompted client #3 to consume the snack. At 4:40pm, GHS #1 stated she "just knew what [client #3] liked and had it ready for her" to eat for a snack after arriving home from workshop. GHS #1 indicated she did not give client #3 the choice of snack. At 4:45pm, GHS #1 and GHS #2 requested client #3's personal funds from the Residential Manager (RM). The RM gave GHS #1 and GHS #2 client #3's funds and GHS #1 and GHS #2 left the group home without client #3 in the</p>		<p>o A post-test onactive treatment will be completed by staff to show competency of the material.</p> <p>The home manager will assure compliance during routine group home observations using the attached active treatment observation form, generally 5 out of every 7 days. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p>				

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	<p>facility van. At 5:20pm, GHS #1 and GHS #2 returned to the group home, gave the RM a store receipt for \$7.86 for a hair product for client #3, and the RM indicated the money was used from client #3's personal funds account. At 5:20pm, GHS #1 and the RM both indicated client #3 was not taken shopping to select her own hair product with GHS #1 and GHS #2. At 5:45pm, GHS #1 and GHS #2 redirected clients #2 and #4 to go sit at the dining room table for supper. At 5:45pm, GHS #1 and GHS #2 set out seven glasses on the kitchen counter, GHS #2 filled the glasses with the same fruit punch drink, GHS #2 carried the seven glasses to the dining room table, and placed one filled glass in front of each client. At 6:00pm, the RM and GHS #1 indicated clients #1, #2, #3, #4, #5, #6, and #7 were not given a choice of drink at supper.</p> <p>Client #1's record was reviewed on 11/18/15 at 12:40pm. Client #1's 8/7/15 ISP (Individual Support Plan) indicated he could make his wants and needs known verbally.</p> <p>Client #2's record was reviewed on 11/18/15 at 11:35am. Client #2's 8/7/15 Individual Support Plan (ISP) indicated to increase the amount of meals she helped prepare, to choose a community</p>			

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W 0249 Bldg. 00	<p>outing, and to prepare a menued item.</p> <p>Client #3's record was reviewed on 11/18/15 at 12:10pm. Client #3's 8/7/15 ISP indicated goals/objectives to prepare a beverage three times daily and when on an outing to make a purchase in the community.</p> <p>Client #4's record was reviewed on 11/18/15 at 10:15am. Client #4's 8/7/15 ISP indicated a goal to prepare her lunch.</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse) was conducted. The QIDP and LPN indicated more than one snack and drink should be available for clients #1, #2, #3, #4, #5, #6, and #7 to choose from. The QIDP indicated client #3 should have gone with the staff to choose her own hair products at the store.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the</p>			

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953			
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	<p>achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #4) and 1 additional client (client #7), the facility failed to implement client #2, #4, and #7's Individual Support Plans (ISP) when opportunities existed.</p> <p>Findings include:</p> <p>1. On 11/17/15 from 2:55pm until 6:00pm, client #4 sat on the sofa and in a chair, laid on the sofa, and slept on the sofa in the living room without activity with five facility staff in the group home. At 4:10pm, GHS (Group Home Staff) #6 asked client #4 to sit up on the sofa. Client #4 sat upright and GHS #6 walked away from client #4. Client #4 laid back down on the sofa and went back to sleep. At 4:15pm, client #4 got up from the sofa, retrieved the newspaper ads, walked to the table, and sat down to read. Client #4 did not wear her eye glasses and was not prompted/offered her eye glasses. Client #4 bent at the waist to lean over the ad page and sat at the dining room table holding the ads. At 4:35pm, client #4 laid on the sofa asleep in the living room without activity. At 4:45pm, GHS #6 retrieved client #6's eye glasses from the secured medication cart, then offered</p>	W 0249	<p>W249 – “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 defined in the individual program plan”</p> <p>The facility failed to implement client #2, #4, and #7's Individual Support Plans (ISP) when opportunities existed. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Staff has been retrained on client choice and active treatment on 12/15/2015. ○ A post-test on active treatment will be completed by staff to show competency of the material. <p>The home manager will assure compliance during routine group home observations using the attached active treatment observation form, generally 5 out of every 7 days. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again.</p>	12/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/23/2015	
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	<p>and encouraged client #4 to sit up from the sofa and wear her eye glasses. From 4:45pm until 5:20pm, client #4 wore her eye glasses and was not offered activity.</p> <p>Client #4's record was reviewed on 11/18/15 at 10:15am. Client #4's 8/7/15 ISP (Individual Support Plan) indicated goals/objectives to wear her eye glasses daily for two hours, to work on a craft once a week, and to work on sign language daily.</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse) was conducted. The QIDP and the LPN both indicated client #4 should have been assisted by the facility staff to change her soiled clothing. The QIDP indicated client #4 should have been engaged and prompted for activities during formal and informal opportunities.</p> <p>2. On 11/17/15 at 3:15pm, GHS #1 asked client #2 to come to the medication room for medication administration. GHS #1 selected client #2's "Tums 500mg (milligrams) chew (for nutrition)," 1 tablet three times daily, dispensed the medication into a medication cup, prompted client #2 to take the medication, and no medication</p>		Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.				

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	<p>teaching was observed. GHS #1 did not name the medication, dosage, and reason for the medication's use.</p> <p>On 11/17/15 at 4:15pm, GHS 1 asked client #7 to come to the medication room for medication administration. GHS #1 selected client #7's "Lorazepam 0.5mg (for Schizoaffective Disorder)" 1 tablet twice a day. GHS #1 dispensed the medication into a medication cup, prompted client #7 to take the medication, and no medication teaching was observed. GHS #1 did not name the medication, dosage, and reason for the medication's use.</p> <p>On 11/17/15 at 5:20pm, GHS #6 asked client #4 to come to the medication room for medication administration. GHS #6 selected client #4's "Buspirone 10mg" 1 tablet 3 times a day for behaviors and "Montelukast 10mg" 1 tablet daily for Asthma. GHS #6 dispensed the medications, client #4 chose the flavor of pudding, GHS #6 opened the capsules to mix with vanilla pudding, and fed the medication mixture to client #4. No medication teaching was observed. GHS #1 did not name the medication, dosage, and reason for the medication's use.</p> <p>Client #2's record was reviewed on 11/18/15 at 11:35am. Client #2's 8/7/15</p>						

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W 0268	<p>ISP (Individual Support Plan) indicated a goal/objective to state the name of her vitamin daily.</p> <p>Client #4's record was reviewed on 11/18/15 at 10:15am. Client #4's 8/7/15 ISP (Individual Support Plan) indicated a goal/objective to wash her hands before medication administration.</p> <p>Client #7's record was reviewed on 11/18/15 at 1:06pm. Client #7's 8/7/15 ISP (Individual Support Plan) indicated a goal/objective to wash his hands before medication administration daily.</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse) was conducted. The QIDP and the LPN both indicated clients #2, #4, and #7's ISP objectives/goals should be implemented by the facility staff during formal and informal opportunities. The LPN indicated the facility staff should teach the clients the names, reasons, and doses of the medications each client was administered when opportunities existed.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT</p>				

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Bldg. 00	<p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, for 1 of 4 sampled clients (client #4) and 2 additional clients (clients #6 and #7), the facility failed to ensure clients #4, #6, and #7's dignity in regard to their personal appearances.</p> <p>Findings include:</p> <p>On 11/17/15 from 2:55pm until 6:00pm, clients #4 and #7 were observed at the group home. From 2:55pm until 6:00pm, client #4 wore a top with dried rings of fluid and dried food spills on the front of her top. Client #4 was not prompted and encouraged to change her top. At 6:00pm, client #4 finished her supper meal. From 2:55pm until 6:00pm, client #7 walked room to room, sat down in the living room in a chair, bent over to sort items on the floor, and while wearing a belt his pants lowered below his buttocks to expose his buttocks and underwear multiple times. Client #7 was not prompted and encouraged to pull up his pants. On 11/17/15 from 5:10pm until 6:00pm, client #6 exited the bathroom, his pants were unzipped, and his skin was in view of client #6's unzipped pants. Client #6 was not prompted and taught personal privacy.</p>	W 0268	<p>W268 – “These policies and procedures must promote the growth, development and independence of the client”</p> <p>The facility failed to ensure clients #4, #6, and #7's dignity in regard to their personal appearances. The plan of correction for these findings is as follows:</p> <ul style="list-style-type: none"> ·Staff has been retrained on how to ensure that the dignity of consumers, especially in regard to personal appearance on 12/15/2015. ·The home manager will assure compliance during routine group home observations, generally 5 out of every 7 days. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter. 	12/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2015
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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953
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W 0368 Bldg. 00	<p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse) was conducted. The QIDP and the LPN both indicated client #4 should have been assisted by the facility staff to change her soiled clothing. Both staff indicated clients #6 and #7 should have been taught and encouraged to wear their clothing to promote their personal dignity.</p> <p>9-3-5(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, for 2 of 4 sampled clients (clients #3 and #4) and 2 additional clients (clients #6 and #7), the facility staff failed to administer clients #3, #4, #6, and #7's medications without error and in accordance with their physician's orders.</p> <p>Findings include:</p> <p>On 11/17/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and</p>	W 0368	<p>W368 – “The system for drug administration must assure that all drugs are administered in compliance with the physician's orders”</p> <p>The facility staff failed to administer clients #3, #4, #6, and #7's medications without error and in accordance with their physician's orders. The plan of correction for these findings is as follows:</p> <ul style="list-style-type: none"> • <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LPN will retrain staff on Medication Refresher no later than 12/15/2015 and this training will include and emphasize how to follow physician's orders, how to 	12/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2015
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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953
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	<p>included the following incidents of failing to administer medications according to each clients' physician orders.</p> <p>-A 9/1/15 BDDS report for an incident on 8/12/15 at 9:00pm indicated "During [client #7's] medication review...it was noted that consumer's Trazodone 50mg (milligrams) (for behaviors) that had not been discontinued by the [client #7's] psych provider on 8/10/15 continued to be given until error was noted on 8/31/15." The report indicated the order had been "yellowed out" and staff continued to administer the medication.</p> <p>-An 8/12/15 BDDS report for an incident on 7/23/15 at 8:00pm indicated client #6's guardian had "sent an e-mail that [client #6's] Lipitor prescription had not been discontinued when it should have been."</p> <p>-An 8/7/15 BDDS report for an incident on 7/30/15 at 7:00am indicated client #6's "Bactrim DS (an antibiotic used to decrease the bacterial infections) was omitted by staff."</p> <p>-A 6/4/15 BDDS report for an incident on 5/24/15 at 7:00am for client #3 indicated "was notified...client did not receive her refill of Trinessa birth control (prescribed</p>		<p>completemedication level checks weekly, training on passing medications that arelabeled appropriately, and pharmacy communication.</p> <ul style="list-style-type: none"> •<input type="checkbox"/>All medicationchanges will be sent to LPN for review and for LPN to assure MAR is updatedappropriately. •<input type="checkbox"/>The LPN willoversee Nursing Services. The monitoring agency is the Nursing Oversight Documentation.This report will be sent to the QDDP and the COO upon each home visitmonthly. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/23/2015
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	<p>medication)...Pharmacy was notified on 5/25/15 (for a refill)...then sent to back up pharmacy on 5/26/15. At that time writer notified Group Home Manager of the need to have medication picked up so medication administration could resume. After contacting the pharmacy today, it was noted that the medication had not been picked up from the back up pharmacy as directed on 5/26/15."</p> <p>-A 6/9/15 BDDS report for an incident on 6/8/15 at 12:00pm indicated client #4 was "to begin Foradil (for the treatment of Asthma) on 6/8/15...[Client #4] did not receive the medication."</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse) was conducted. The QIDP and LPN both indicated medication should be administered according to physician's orders and Core A/Core B Living in the Community Medication Training. The LPN indicated staff failed to ensure clients were given the correct medications as prescribed by their personal physician's. The QIDP and LPN both indicated medications should be available at the group home for administration and "if the medications were not available the agency nurse</p>				

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953
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W 0382 Bldg. 00	<p>should be notified immediately." The QIDP indicated no further information was available for review.</p> <p>On 11/17/15 at 1:30pm, a review of the Core A/Core B Living in the Community Medication Training 4/2011 indicated staff should administer client medications according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 2 of 20 medications administered during the morning medication administration period (clients #3 and #5), the facility failed to keep medications locked when not being administered.</p> <p>Findings include: On 11/18/15 at 6:40am, GHS (Group</p>	W 0382	<p>W382 – “The facility must keep all drugs and biological locked except when being prepared for administration” The facility staff failed to administer clients #3, #4, #6, and #7's medications without error and in accordance with their physician's orders. The plan of correction for these findings is as follows: ●□□□□□□□□ The LPN has provided retraining to all home staff on 12/15/2015 on how to secure and</p>	12/15/2015

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953			
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	Home Staff) #3 administered client #3's oral medications. At the end of client #3's medication administration period GHS #3 selected client #3's "Polyethylene Glycol 3350 (Miralax)" for constipation, poured 17 grams into a cup, poured the measured 17 grams into a bright yellow glass, and carried the glass to the kitchen. GHS #3 set the medication in the glass on the kitchen counter and walked away from the medication. GHS #7 walked into and out of the kitchen with client #4. At 7:02am, client #5 went into the medication room with GHS #3. At 7:10am, GHS #3 carried a second bright yellow glass to the kitchen and set the glass on the counter next to client #3's unsecured medication. GHS #7 indicated the second glass of medication was client #5's Polyethylene Glycol 3350 (Miralax) a constipation medication. From 7:10am until 7:35am, clients #3 and #5's Polyethylene Glycol medication sat in two bright yellow glasses unsecured on the kitchen counter. From 7:10am until 7:35am, client #4 held clients #3 and #5's unsecured glasses of powdered medication in the kitchen multiple times, tilted the glasses upward, attempting to drink, and GHS #7 took the glasses and placed them back onto the unsecured kitchen counter. At 7:35am, GHS #7 mixed juice with the two glasses of		storemedications. All medication changes will be sent to LPN for reviewand for LPN to assure MAR is updated appropriately. ·The home manager will assure compliance during routine medication observations. The manager will explicitly monitor the security of the medications at 75% of applicable medication passes x1 week. The manager, if observations confirm compliance, can reduce the frequency of confirmation to 50% of applicable medication passes x1 week. If observations confirm non-compliance, must increase to 100% of applicable med passes. Ongoing monitoring will occur each day that the manager is at the home for a period of one month. The frequency is generally 5 days out of every 7. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.				

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953
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	<p>Polyethylene Glycol medication, stirred, set the glasses on the table, and walked away from the table.</p> <p>Client #2's record was reviewed on 11/18/15 at 11:35am. Client #2's 9/1/15 Physician's Order and 11/2015 MAR (Medication Administration Record) both indicated "Polyethylene Glycol 3350" for constipation 17 grams in liquid daily.</p> <p>On 11/18/15 at 7:35am, client #5's 11/2015 MAR indicated "Polyethylene Glycol 3350" 17 grams in liquid daily for constipation.</p> <p>An interview was conducted on 11/19/15 at 19:55am, with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse). The QIDP and LPN both indicated the medications should be kept secured when not administered. The LPN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to clients #3 and #5's unsecured medications in the kitchen and at the dining room table. The LPN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 11/18/15 at 1:00pm, a record review of the facility's undated "Living in the</p>			

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W 0460 Bldg. 00	<p>Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured and staff should watch clients consume their medications.</p> <p>9-3-6(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #2) who had a prescribed modified diet, the facility failed to ensure client #2's modified diet texture was prepared at the recommended consistency.</p> <p>Findings include:</p> <p>On 11/17/15 at 3:30pm, GHS (Group Home Staff) #4 selected and prepared graham crackers in a bowl and set the bowl on the dining room table. GHS #4 asked client #2 if she wanted the prepared snack of graham crackers soaked in thin consistency milk. Client #2 consumed the snack. At 3:30pm, GHS #4 indicated the milk she poured over client #2's graham crackers was not</p>	W 0460	<p>W460 – “Each client must receive a nourishing,well-balanced diet including modified and specially prescribed diets” The facility failed to ensurethat client #2’s modified diet texture was prepared at the recommendedconsistency. The plan of correction for these findings is as follows: <ul style="list-style-type: none"> Staff retraining hasoccurred on the different types of diets (i.e. puree, mechanical soft) on 12/15/2015. The home manager will assure compliance during routine group home observations, generally 5 out of every 7 days. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not</p>	12/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/23/2015	
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	<p>thickened to a honey consistency. At 5:20pm, GHS #1 stirred client #2's bread and butter mixed with a fork and mashed with milk. At 5:20pm, GHS #1 placed the bowl on the table in front of client #2 and indicated it was bread and butter. GHS #1 indicated the bread was a soup consistency. At 5:45pm, GHS #1 indicated a mechanical soft diet needed a smooth consistency for bread.</p> <p>Client #2's record was reviewed on 11/18/15 at 11:35am. Client #2's 8/7/15 Individual Support Plan (ISP) indicated she was on a Mechanical Soft diet. Client #2's 9/1/15 Physician's Order indicated she was to receive a Mechanical Soft diet. Client #2's 8/24/15 Nutritional assessment completed by the Registered Dietician indicated client #2 was to receive a Mechanical Soft diet with honey thickened liquids because she was a choking risk.</p> <p>On 11/18/15 at 11:50am, a review of the facility's undated "9/16/13 Guidelines for Mechanical Soft Diet" policy and procedure indicated "...Using the regular menu...prepare the Mechanical Soft Diet. Toast, Bread...cut into pieces and moisten with milk until soft...Foods on this diet are easy to chew, cut into 1/4" (inch) to 1/2" cubes, moist, and mashable in the mouth..."</p>		<p>been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/23/2015	
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W 0475 Bldg. 00	<p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse) was conducted. The QIDP and the LPN both indicated client #2 should receive bread soaked/moistened with milk. The LPN indicated the agency's mechanical soft diet guidelines was not followed when client #2's bread was pureed.</p> <p>9-3-8(a)</p> <p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled client (client #4) who used adaptive eating equipment, the facility failed to encourage and have available client #4's small youth utensils during dining opportunities.</p> <p>Findings include:</p> <p>On 11/17/15 from 2:55pm until 6:00pm and on 11/18/15 from 6:05am until 8:05am, client #4 was observed at the group home, ate meals with regular size utensils, and no small silverware was observed to be available.</p>	W 0475	<p>W475 – “Food must be served with appropriateutensils” The facility failed toencourage and have available client #4’s small youth utensils during diningopportunities. The plan of correction for these findings is as follows: •□□□□□□□□Staff retraining hasoccurred on providing the appropriate utensils, as well as client #4’s diningplan by 12/15/2015. ·The home manager will assure compliance during routine group home observations, generally 5 out of every 7 days. After one month the QIDP and Group Home manager can re-evaluate the need of</p>	12/15/2015			

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W 9999 Bldg. 00	<p>Client #4's record was reviewed on 11/18/15 at 10:15am. Client #4's 8/7/15 ISP (Individual Support Plan) indicated client #4 used "small silverware." Client #4's 8/2015 "Dining/Dysphagia Management Plan" indicated client #4 was at risk to choke and needed to use a small youth spoon to consume her meals. Client #4's 9/10/15 "Nutritional Assessment" indicated client #4 was to use small silverware to eat with.</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Agency LPN (Licensed Practical Nurse) was conducted. The QIDP and the LPN both indicated client #4 should have been taught and encouraged to use her small silverware to eat with.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p>	W 9999	<p>observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p> <p>W9999 – “Final observations” The following Community Residential Facilities for Persons with Developmental Disabilities rule was notmet: The residential provider shall report the following circumstances to</p>	12/15/2015			

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	<p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division (16) A medication error...as follows: a. wrong medication given. c. missed medication-not given.</p> <p>This state rule is not met as evidence by:</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #3) and 2 additional clients (clients #6 and #7), the facility staff failed to immediately report to the Bureau of Developmental Disabilities Services (BDDS) and to the facility administrator regarding clients #3, #6, and #7's medication errors.</p> <p>Findings include:</p> <p>On 11/17/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and included the following incidents of failing to immediately report medication errors:</p> <p>-A 9/1/15 BDDS report for an incident on 8/12/15 at 9:00pm indicated "During [client #7's] medication review...it was</p>		<p>the division by telephone no later than the first business day followed by written summaries as requested by the division (16) A medication error: as follows: a. wrong medication given c. missed medication – not given. The plan of correction for these findings is as follows:</p> <ul style="list-style-type: none"> ·Mandatory retraining on Policy and Procedures with regard to reporting regulations has occurred with all applicable staff by the manager of the home on 12/15/2015. ·DDRS Incident Reporting Regulations ·The Director of Group Homes and/or Chief Operations Officer will review all submitted documentation, BDDS reports, as well as any documentation from Group Home Observations to identify any late reporting of medication errors. 		

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	<p>noted that consumer's Trazodone 50mg (milligrams) (for behaviors) that had not been discontinued by the [client #7's] psych provider on 8/10/15 continued to be given until error was noted on 8/31/15." The report indicated the order had been "yellowed out" and staff continued to administer the medication.</p> <p>-An 8/12/15 BDDS report for an incident on 7/23/15 at 8:00pm indicated client #6's guardian had "sent an e-mail that [client #6's] Lipitor prescription had not been discontinued when it should have been."</p> <p>-An 8/7/15 BDDS report for an incident on 7/30/15 at 7:00am indicated client #6's "Bactrim DS (an antibiotic used to decrease the bacterial infections) was omitted by staff."</p> <p>-A 6/4/15 BDDS report for an incident on 5/24/15 at 7:00am for client #3 indicated "was notified...client did not receive her refill of Trinessa birth control (prescribed medication)...Pharmacy was notified on 5/25/15 (for a refill)...then sent to back up pharmacy on 5/26/15. At that time writer notified Group Home Manager of the need to have medication picked up so medication administration could resume. After contacting the pharmacy today, it was noted that the medication had not</p>			

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	<p>been picked up from the back up pharmacy as directed on 5/26/15."</p> <p>On 11/19/15 at 9:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse) was conducted. The QIDP indicated the facility followed the BDDS policy and procedure. The QIDP indicated the facility staff failed to immediately report medication administration errors. The QIDP and LPN both indicated medication should be administered according to physician's orders and Core A/Core B Living in the Community Medication Training. The LPN indicated staff failed to ensure clients were given the correct medications as prescribed by their personal physicians. The QIDP and LPN both indicated medications should be available at the group home for administration and "if the medications were not available the agency nurse should be notified immediately." The QIDP indicated no further information was available for review.</p> <p>9-3-1(b)</p>			