

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 10/23/2014
--	---	--	---

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
W000000	<p>This visit was for the investigation of Complaint #IN00156294.</p> <p>Complaint #IN00156294: Substantiated, Federal/state deficiency related to the allegation(s) is cited at W153.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 10/16, 10/17, 10/22, and 10/23/14.</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. Quality Review completed 10/28/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000153	<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.</p>			

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 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/23/2014	
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>Based on record review and interview, for 1 of 3 allegations reported to BDDS (Bureau of Developmental Disabilities Services) reviewed (client A), the facility staff failed to immediately report an allegation of staff to client abuse to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law 9-3-1(b)(5).</p> <p>Findings include:</p> <p>On 10/16/14 at 1:30pm, the facility's BDDS Reports and investigations were reviewed from 07/1/14 through 10/16/14. The review indicated the following for client A:</p> <p>-An 8/31/14 BDDS report for an incident reported on 8/29/14 at 12:30pm, indicated "This report is late due to being unable to access the Internet to send the report. It was reported on 8/30/14 at 8:53am, that on 8/29/14 at 12:30pm, during (the company owned) day services [Client A] was observed by a staff to be in the computer/med (medication) room away from others due to behavior outbursts. It was also reported that [Client A] was having trouble with her breathing during this time. It was reported that [Client A] was left in the room for approximately 2 hours and was</p>	W000153	<p>W153 Staff Treatment of Clients</p> <p>This item outlines that the agency failed to immediately report allegations of abuse/neglect/mistreatment to the facility administrator and to BDDS. The plan of correction for this tag is as follows:</p> <p>Correction:</p> <p>Training with all staff will occur no later than 11/22/2014 on</p> <ul style="list-style-type: none"> ·DDRS Incident Reporting Regulations 460 code ·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 ·Clarification that at no time can staff have visitors in the home. <p>Staff training will stress the importance that all staff know as required by law, it is the responsibility of each person to report suspected instances of abuse, neglect and exploitation to the appropriate authorities, as well as to the administrator immediately upon learning of the suspected ANE. Failure to follow</p>	11/22/2014			

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 10/23/2014
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	
	told by staff that she could not come out till calm. All staff present at the (company owned) day services was suspended pending the investigation (sic). Investigation Summary: [Day Service (DS) Staff #8] had [client A] go to the computer/med room to calm down due to hitting on tables, yelling, and upset (sic) other consumers (at day services). [Client A] was not having difficulty breathing while in the room. The door (to the computer/med room) was left open the whole time [Client A] (was) in the room and was informed that [client A] could come out when calm. [Client A] was removed from the area because she was disrupting other (clients) programming, which could be seen as abusive towards others. [Client A's] bps (sic) (Behavior Support Plan (BSP) doesn't have anything about her going to another area when upset...Conclusion is that no staff was abusive or neglectful...All staff need and will receive training on reporting allegation(s) timely...." The report indicated the staff at the day services "was informed verbally by the Director of Group Homes the importance of reporting immediately. Do not wait. Must protect all clients from ANE (Abuse, Neglect, and Exploitation) situations immediately and report immediately...."		the agency policy and procedures will result in disciplinary action. ·See copy of in-service training verification forms and copies of Policy and Procedures. ·Retraining on the above topics will be conducted with the group home staff at least quarterly. All copies of training verifications will be sent to the Director of Group Homes to ensure training is completed quarterly. Monitoring: During visits at the group home the Residential Manager, the LPN and the Director of Group Homes will conduct random questioning of staff to ensure that all staff have a clear understanding and expectation of Who, What, When, Why and How to report ANE. This information will be documented on the Group Home Observation reports and a copy forwarded to the Director of Group Homes. The Residential Manager will complete 2 weekly observation reports for the next 3 months. The Residential Nurse/LPN and the Director of Group Homes will complete at least 1 unannounced visit monthly through 12/31/14. All copies of training verifications will be sent to the Director of Group Homes to ensure training is completed.		

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 10/23/2014
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	
W000154	<p>On 10/23/14 at 10:00am, an interview with the CEO (Chief Executive Officer), the COO (Chief Operations Officer) and the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP and the COO indicated the agency followed the BDDS reporting guidelines. The DGH/QIDP stated "all" allegations of abuse, neglect, and/or mistreatment should be reported to the administrator and to BDDS in accordance with State Law. The DGH/QIDP stated "No" the allegation for client A was not immediately reported by multiple staff members to the administrator and/or BDDS. The DGH/QIDP indicated one of the facility owned Day Services staff reported to the agency of an allegation to client A and the staff were immediately suspended when the agency became aware of the allegation.</p> <p>This federal tag relates to complaint #IN00156294.</p> <p>9-3-1(b)(5) 9-3-2(a) 483.420(d)(3)</p>		<p>Allcorrective actions related to tag W153 will be implemented on or before11/22/14</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 10/23/2014	
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>STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 1 of 1 injury of unknown origin reviewed (client C), the facility failed to complete a thorough investigation of client C's injury of unknown origin.</p> <p>Findings include:</p> <p>On 10/16/14 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 07/1/14 through 10/16/14. No formal investigations for client C were available for review. The review indicated one (1) BDDS report for client C from 8/11/14 through 9/6/14.</p> <p>-A 9/6/14 BDDS (Bureau of Developmental Disabilities Services) report for an incident reported on 9/6/14 at 1:38pm, indicated client C had "Unexplained bruises on her left arm ranging from 1" (one inch) to 3" (three inches) size of a circle and no skin assessment was done on 2nd (second) shift, other staff came in, and observed them (the bruises) possible bumping into things or objects...Corrective action will be given for no skin assessments completed...An investigation to cause of</p>	W000154	<p>W154 Staff Treatment of Clients This item outlines that the facility failed to provide evidence that all allegations of violations are thoroughly investigated. The plan of correction for these findings is as follows:</p> <p>Correction: The CEO completed training with the Director of Group Homes/QDDP and the Corporate Compliance Officer/Interim COO regarding proper identification, thorough investigation, and timely reporting of all allegations of abuse, neglect, and/or mistreatment, and to complete the monitoring requirements of all plans of correction.</p> <p>A meeting was conducted on Wednesday 10/8/14 with the CEO, CCO/Interim COO, Director of Group Homes/QDDP, Nursing staff, Workshop Production Manager, and ICC's to review the expectations related to thorough and timely ANE investigations and reporting.</p> <p>Steve Cory conducted training on Investigations on 10/27/14. Administrative and</p>	11/22/2014			

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 10/23/2014	
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>injury of unknown is being completed additional info. (information) to be sent."</p> <p>On 10/16/14 at 1:30pm, on 10/17/14 at 9:00am, on 10/22/14 at 9:00am, and on 10/23/14 at 10:00am, client C's investigation of 9/6/14 unknown injuries was requested from the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse).</p> <p>On 10/23/14 at 10:00am, client C's "Accident/Incident Reports" from 9/1/14 through 10/16/14 were reviewed and included the following:</p> <p>-On 9/6/14, no time recorded, "Accident/Incident Report" indicated client C was in her bedroom, "was hurriedly walking out of her room and ran into corner of dresser with some force. It will probably bruise. Area of impact is upper arm, right side...Summary of Investigation...A investigation was conducted and staff were told not to throw away any items before new was purchased (signed by Residential Manager)." No further information were available for review.</p> <p>-On 9/6/14, 10:34am, "Accident/Incident Report" indicated client C was in her</p>		<p>Management personnel from all program areas were in attendance.</p> <p>Monitoring: The CCO will report all allegations of ANE to the CEO and will maintain a log including the summary of each resulting investigation and the final outcome. The CEO or his designee will conduct random reviews of allegations, interviews and action taken to ensure that:</p> <ul style="list-style-type: none"> · Agency administrative staff have properly identified allegations of abuse, neglect, and/or mistreatment · All agency staff have reported allegations of ANE in accordance with the agency's guidelines for timeliness · A complete and thorough investigation has been conducted for all allegations of ANE <p>All corrective actions related to tag W154 will be implemented on or before 11/22/14</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 10/23/2014
--	---	--	---

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>bedroom, "Staff had gotten [client C] new bras and was assisting putting [client C's] on when bruises discovered on skin assessment were found. Supervisor/ (Residential) House Manager was notified...Summary of Investigation...It was found (client C had) type (of) a behavior by my investigation due to [client C's] bras (were) thrown away." No further information were available for review.</p> <p>On 10/22/14 at 9:00am, the DGH/QIDP indicated it was the agency's policy to complete investigation into injuries of unknown origin/source. The DGH/QIDP indicated client C's information did not document the origin/source of client C's unknown injuries recorded on 9/6/14 to her left arm. The DGH/QIDP indicated no documented witness statements, formal investigative notes, monitoring or observations, and dates with times of persons interviewed were available for review.</p> <p>On 10/23/14 at 10:00am, an interview with the CEO (Chief Executive Officer), the COO (Chief Operations Officer) and the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities</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 10/23/2014
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	
	Professional) was conducted. The DGH/QIDP indicated injuries of unknown origin/source should be thoroughly investigated. The DGH/QIDP stated "No" the unknown injury of client C's left arm was not thoroughly investigated. 9-3-2(a)				