

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
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W 0000 Bldg. 00	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: 5/17, 5/18, 5/19, 5/20, and 5/27/2016.</p> <p>Facility Number: 000833 Provider Number: 15G314 AIM Number: 100243960</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 6/06/2016 by #09182.</p>	W 0000		
W 0149 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 record review and interview, for 6 of 7 investigations of allegations of abuse, neglect, and/or mistreatment reviewed (for clients #3, #5, #6, Discharged client #9, and Discharged client #10) and reported and for 5 of 32 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility neglected to implement its Abuse, Neglect, and/or Mistreatment</p>	W 0149	<p>W149 – “The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.” 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 to the administrator, to Adult Protective Services, and to BDDS</p>	06/26/2016

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>policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator, to Adult Protective Services (APS) IC 12-10-3, and to BDDS in accordance to State Law, to ensure staff were available to supervise clients, and to ensure implementation of sufficient corrective actions for client #3's medication errors, staff to client interactions, and staff supervision while in the community for clients #5, #6, Discharged clients #9 and #10.</p> <p>Findings include:</p> <p>On 5/17/16 at 1:00pm and on 5/27/16 at 9:00am, the facility's BDDS reports and investigations were reviewed from 5/1/15 through 5/17/16 and indicated the following for allegations of abuse, neglect, and/or mistreatment:</p> <p>1. For client #3's insulin errors: -A 1/5/16 BDDS report for an incident on 1/4/16 at 12:43pm indicated new order today 1/4/16 "received via fax for give (sic) 20U (Units) Novolog (insulin) now recheck in 1 hour, on 1/4/16 had not been administered as ordered." The report indicated the non licensed medical assistant in the agency office stated "that [client #3] had come into the Health Office yesterday morning stating his</p>		<p>inaccordance to State Law, to ensure staff were available to supervise clients, andto ensure implementation of sufficient corrective actions for medicationerrors, staff to client interactions, and staff supervision while in thecommunity. The plan of 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 by 06/26/2016. ·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 stressthe importance that all staff knows it is the responsibility of each person toreport suspected instances of abuse, neglect and exploitation immediately andthat the facility Administrator/Administrator on Duty (AOD) and BDDS must also be notified. The manager will be responsible for assuring that the reportingregulations, policies and procedures are followed.</p>		

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	<p>blood sugar had been elevated. Assistant contacted [client #3's] Endocrinologist and left a message for the nurse. Nurse contacted Assistant and gave verbal orders to give the above medication. Assistant noted that a verbal order would not be acceptable and order would need to be sent to the agency prior to medication being administered. Assistant called Endocrinologist's nurse and left a voicemail requesting this information. No call received, however fax was sent by physician's office. Fax machine is secured and was not checked until after 2pm. Therefore, order was received today (1/5/16) and medication order for the above had been omitted."</p> <p>-A 12/12/15 BDDS report for a an incident on 11/4/15 at 12:00pm indicated "During a quarterly meeting on 12/11/15 it was brought to the Director of Group Homes (sic) attention that a BDDS report for a medication error was not done. On 11/4/15 [client #3] received his 10 unit of Novolog injection. The Physician's order says hold the Novolog if [client #3's] sugar is less than 70. Staff administered the Novolog anyway's (sic)." The report did not indicate client #3's Blood Sugar results. No investigation and no corrective action were available for review.</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 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. ·The QIDP and/or Director 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. ·Medication errors are monitored by the Medication Error Task Force and a Medication Error Review meeting is held every Friday to discuss why the medication error occurred. Employees are required to attend the medication error review meeting and disciplinary action/retraining is enforced after the review. ·The home manager will assure compliance during routine group home observations generally 5 out of every 7 days, to assure staff are completing the 		

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	<p>2. For allegations of abuse, neglect, and/or mistreatment: -A 2/9/16 "Investigative Report...Initiated due to Abuse/Neglect of Consumer [Discharged client #9]...It was brought to my attention that [Group Home Staff (GHS) #10] had taken [clients #5, #6, Discharged client #9, and Discharged client #10] to her home after an outing on Sunday 2/2/16. Upon arrival at her home she took three of the consumers into her home leaving [Discharged client #9] asleep in the van." The investigation indicated "Comments/Explanation...Upon talking with [GHS #10] she has admitted that she did stop at her home and that she left [Discharged client #9] asleep in the van. She stated that it was not for a very long period of time, about five minutes. [GHS #10] then blew up in the office stating that this was a bunch of [expletive] and that she was not in the mood for it today...She then got up and left the office. She approached [client #9] in the dining room and said to her I know you are the one who told and you will never go anywhere with me again...." -Client #6's witness statement indicated she "was excited to be able to see [name], [GHS #10's] mother in law, Lucky the dog, and her friend [name] [GHS #10's] husband." -A 2/10/16 "Investigation initiated due to</p>		<p>Medication Error Review . 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 QIDP during home visits monthly. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter. ·The QDDP will complete training with all investigatory managers no later than 06/26/2016 to ensure the agency's administrative staff identify an allegation of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment. ·The policy for Investigations has been updated to include employee's documented statements (e.g. email would be acceptable). All interviewees will be asked to provide a statement in their own words and if they are unable or unwilling to do so, the reason for this will be documented. We will identify all</p>				

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	<p>Staff yelling at [clients #5 and Discharged client #9]...[GHS #10] was already suspended at the time of incident and remained suspended until termination on 2/10/16...During an investigatory interview [GHS #10] stormed out of the office at the [name of group home] and started yelling at [client #5] saying she knew it was her who told and that she was never taking her anywhere ever again...Employee has already been terminated for this and another investigation that led to this encounter."</p> <p>-A 12/8/15 BDDS report for an incident on 12/8/15 at 10:16am indicated client #5 reported to the QIDP (Qualified Intellectual Disabilities Professional) of "an allegation of neglect and (the allegation) was turned over to the corporate compliance officer and an investigation is underway." No investigation was available for review and no information regarding this incident was available for review.</p> <p>-A 12/10/15 BDDS follow up indicated "What was being alleged? There was an allegation of inappropriate communication between staff and consumer...Staff (Group Home Staff #21) was suspended pending the outcome of the investigation."</p> <p>-A 12/10/15 BDDS follow up indicated</p>		<p>clients who have been a witness to or otherwise effected by the alleged incident of ANE will, in as much as they are able and appropriate, be included in the investigation/interview process. The policy has been updated accordingly. All clients involved or potentially involved will also be interviewed or represented during the investigatory process. This will occur no later than 06/26/2016.</p> <p>·All investigatory managers will be retrained on this policy and procedure before 06/26/2016.</p> <p>·The QDDP will review all allegations, interviews and action taken to ensure that the agency administrative staff identify allegations of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p>		

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	<p>"the allegation was not substantiated and staff was returned to work."</p> <p>-A 11/1/15 BDDS report for an incident on 10/31/15 at 3:00pm indicated the RM (Residential Manager) was "made aware of a situation that occurred yesterday and last evening at the house. In talking to staff that were here and clients, two staff [Group Home Staff (GHS) #20 and GHS #2] were using profanity toward [client #5]...Staff suspended."</p> <p>-A 11/1/15 "Investigation" for an "Investigation initiated due to Verbal abuse to a Consumer [client #5]" indicated a type written summary of event and interviews completed on 11/2/15 which paraphrased responses from staff the previous day. The "Comments/Explanation" indicated:</p> <p>-GHS (Group Home Staff) #8 indicated by "phone on 11/1/15 and then a written statement was completed by her on 11/2/15 according to [name of GHS #10's] written statement and in talking to her she witnessed the above mentioned staff being verbally abusive to [client #5].</p> <p>-Client #3 was talked to in person on 11/1/15 at 11:05am and "also gave a written statement at that time. He states that he felt [name of GHS #20] was being bossy with him and that she was cussing a lot."</p>			

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	<p>-Discharged client #9 stated GHS #2 was "cussing and got in staff [name of GHS #10's] face after [name of GHS #10] asked her to please stop. She also stated that [GHS #20] stated at this point she hated her f----- job."</p> <p>-Client #5 stated that GHS #20 "was mean to her and cussed at her."</p> <p>The investigation did not include the questions asked, a summary of events, findings, corrective actions, and/or the actual written witness statements by the staff and clients interviewed during the investigation.</p> <p>-A 5/5/15 BDDS report for an incident on 4/29/15 at 12:00pm indicated the BDDS office "received a call from [Discharged Client #10's] mother/guardian. She stated that on Wednesday 4/29/15 [Discharged client #10] was left without staff while at swim practice. She went on to say that on the way over to swim practice, staff received a phone call stating that he had the med. (medication) room key and needed to return to the group home ASAP (As Soon As Possible). She stated that staff dropped [Discharged client #10] off at swim practice without letting Special Olympics staff know she did not have staff. [Discharged client #10] had the emergency cell phone for the van and called the house manager stating she was</p>						

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	<p>without staff."</p> <p>-A 5/1/15 Follow Up report indicated Discharged Client #10 was "without staff, no more than 30 minutes. The staff reported he discussed with an off duty lifeguard to watch [discharged client #10], and this (sic) the lifeguard agreed." The follow up indicated "the results of the investigation: Results are that the staff was acting per the direction of a senior staff person to return the med. cart keys to the home for another client's insulin injection. The staff followed the direction to leave the consumer under the monitoring of another person. However [staff name] did not leave [Discharged client #10] with a Carey Services staff person who was trained on [Discharged client #10] (sic). Instead he left the consumer under the monitoring of an off duty lifeguard. This is not acceptable practice...Allegation Substantiated."</p> <p>On 5/27/16 at 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated allegations were not reported immediately to the administrator and to BDDS in accordance with state law and should have been. The QIDP indicated the facility staff neglected to follow the agency's policy and procedure to protect the clients from abuse, neglect,</p>			

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	<p>and/or mistreatment. The QIDP stated clients living in the group home "required" twenty-four hours a day, seven days a week, staff supervision for community outings and medication administration. The QIDP indicated staff should not use profane language when communicating with clients. The QIDP indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations.</p> <p>On 5/17/16 at 1:00pm, 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))."</p>			

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W 0153 Bldg. 00	<p>On 5/17/16 at 1:00pm, the facility's 6/2011 "Procedures for Reporting abuse, neglect, and other Reportable or Unusual Incidents" indicated "As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and exploitation...Staff and volunteers are provided training and/or tested for competency on an annual basis regarding their responsibilities in reporting such incidents to authorities as well as to agency's administrators immediately upon learning of the suspected abuse/neglect/exploitation." The policy indicated reportable incidents are "1. Any alleged, suspected, or actual abuse, neglect, or exploitation of a consumer."</p> <p>9-3-1(b)(5) 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 1 of 7 investigations reviewed (clients #5, #6, Discharged client #9, and Discharged client #10) and for 3 of 32 BDDS (Bureau of Developmental</p>	W 0153	W153 – “The facility must ensure that allallegations of mistreatment, neglect or abuse, as well as injuries of unknownsource, are reported immediately to the	06/26/2016	

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	<p>Disabilities Services) reports reviewed, the facility failed to immediately report an allegation of verbal abuse, client #3's medication error, and lack of staff supervision to state officials (Bureau of Developmental Disabilities Services-BDDS IAC 9-3-1(b)(5) and/or Adult Protective Services -APS) IC 12-10-3 in accordance with state law.</p> <p>Findings include:</p> <p>On 5/17/16 at 1:00pm and on 5/27/16 at 9:00am, the facility's BDDS reports and investigations were reviewed from 5/1/15 through 5/17/16 and indicated the following for allegations of abuse, neglect, and/or mistreatment:</p> <p>1. For client #3's insulin errors: -A 12/12/15 BDDS report for a an incident on 11/4/15 at 12:00pm indicated "During a quarterly meeting on 12/11/15 it was brought to the Director of Group Homes (sic) attention that a BDDS report for a medication error was not done. On 11/4/15 [client #3] received his 10 units of Novolog (insulin) injection. The Physician's order says hold the Novolog if [client #3's] sugar is less than 70. Staff administered the Novolog anyway's (sic)." The report did not indicate client #3's Blood Sugar results. No investigation and no corrective action</p>		<p>administrator or to other officials in accordance with State law through established procedures." The facility failed to immediately report an allegation of verbal abuse, client #3's medication error, and lack of staff supervision to state officials and/or Adult Protective Services in accordance with state law. The plan of 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 06/26/2016. ·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</p>		

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	<p>were available for review.</p> <p>2. For allegations of abuse, neglect, and/or mistreatment: -A 2/9/16 "Investigative Report...Initiated due to Abuse/Neglect of Consumer [Discharged client #9]...It was brought to my attention that [Group Home Staff (GHS) #10 had taken [clients #5, #6, Discharged client #9, and Discharged client #10] to her home after an outing on Sunday 2/2/16. Upon arrival at her home she took three of the consumers into her home leaving [Discharged client #9] asleep in the van." The investigation indicated "Comments/Explanation...Upon talking with [GHS #10] she has admitted that she did stop at her home and that she left [Discharged client #9] asleep in the van. She stated that it was not for a very long period of time, about five minutes. [GHS #10] then blew up in the office stating that this was a bunch of [expletive] and that she was not in the mood for it today...She then got up and left the office. She approached [client #9] in the dining room and said to her I know you are the one who told and you will never go anywhere with me again...." -Client #6's witness statement indicated she "was excited to be able to see [name], [GHS #10's] mother in law, Lucky the dog, and her friend [name] [GHS #10's] husband."</p>		<p>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 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. The QIDP and/or Director 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. The QDDP will complete training with all investigatory managers no later than 06/26/2016 to ensure the agency's administrative staff identify an allegation of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly 		

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	<p>3. A 5/5/15 BDDS report for an incident on 4/29/15 at 12:00pm indicated the BDDS office "received a call from [Discharged Client #10's] mother/guardian. She stated that on Wednesday 4/29/15 [Discharged client #10] was left without staff while at swim practice. She went on to say that on the way over to swim practice, staff received a phone call stating that he had the med. (medication) room key and needed to return to the group home ASAP (As Soon As Possible). She stated that staff dropped [Discharged client #10] off at swim practice without letting Special Olympics staff know she did not have staff. [Discharged client #10] had the emergency cell phone for the van and called the house manager stating she was without staff."</p> <p>-A 5/1/15 Follow Up report indicated Discharged Client #10 was "without staff, no more than 30 minutes. The staff reported he discussed with an off duty lifeguard to watch [discharged client #10], and this (sic) the lifeguard agreed." The follow up indicated "the results of the investigation: Results are that the staff was acting per the direction of a senior staff person to return the med. cart keys to the home for another client's insulin injection. The staff followed the</p>		<p>investigating all allegations of abuse, neglect, and/or mistreatment.</p> <p>·The policy for Investigations has been updated to include employee's documented statements (e.g. email would be acceptable). All interviewees will be asked to provide a statement in their own words and if they are unable or unwilling to do so, the reason for this will be documented. We will identify all clients who have been a witness to or otherwise effected by the alleged incident of ANE will, in as much as they are able and appropriate, be included in the investigation/interview process. The policy has been updated accordingly. All clients involved or potentially involved will also be interviewed or represented during the investigatory process. This will occur no later than 06/26/2016.</p> <p>·All investigatory managers will be retrained on this policy and procedure before 06/26/2016.</p> <p>·The QDDP will review all allegations, interviews and action taken to ensure that the agency administrative staff identify allegations of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and</p>		

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W 0154 Bldg. 00	<p>direction to leave the consumer under the monitoring of another person. However [staff name] did not leave [Discharged client #10] with a Carey Services staff person who was trained on [Discharged client #10] (sic). Instead he left the consumer under the monitoring of an off duty lifeguard. This is not acceptable practice...Allegation Substantiated."</p> <p>On 5/27/16 at 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated allegations were not reported immediately to the administrator and to BDDS in accordance with state law and should have been.</p> <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. Based on record review and interview, for 2 of 7 investigations of allegations of</p>	W 0154	<p>thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p> <p>·Medication errors are monitored by the Medication Error Task Force and a Medication Error Review meeting is held every Friday to discuss why the medication error occurred. Employees are required to attend the medication error review meeting and disciplinary action/retraining is enforced after the review.</p> <p>·The home manager will assure compliance during routine group home observations, generally 5 out of every 7 days, to assure staff are completing the Medication Error Review . 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 QIDP during home visits monthly. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p> <p>W154 – “The facility must have evidence thatall alleged</p>	06/26/2016	

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	<p>abuse, neglect, and/or mistreatment reviewed (for clients #3, #5, #6, Discharged client #9, and Discharged client #10) and reported and for 2 of 32 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to thoroughly investigate allegations of staff verbal abuse and discharged client #10 being left alone at swim practice.</p> <p>Findings include:</p> <p>On 5/17/16 at 1:00pm and on 5/27/16 at 9:00am, the facility's BDDS reports and investigations were reviewed from 5/1/15 through 5/17/16 and indicated the following for allegations of abuse, neglect, and/or mistreatment:</p> <p>-A 11/1/15 BDDS report for an incident on 10/31/15 at 3:00pm indicated the RM (Residential Manager) was "made aware of a situation that occurred yesterday and last evening at the house. In talking to staff that were here and clients, two staff [Group Home Staff (GHS) #20 and GHS #2] were using profanity toward [client #5]...Staff suspended."</p> <p>-A 11/1/15 "Investigation" for an "Investigation initiated due to Verbal abuse to a Consumer [client #5]" indicated a type written summary of</p>		<p>violations are thoroughly investigated." The facility failed to thoroughly investigate allegations of staff verbal abuse and discharged client #10 being left at swim practice: The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> The QDDP will complete training with all investigatory managers no later than 06/26/2016 to ensure the agency's administrative staff identify an allegation of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment. The policy for Investigations has been updated to include employee's documented statements (e.g. email would be acceptable). All interviewees will be asked to provide a statement in their own words and if they are unable or unwilling to do so, the reason for this will be documented. We will identify all clients who have been a witness to or otherwise effected by the alleged incident of ANE will, in as much as they are able and appropriate, be included in the investigation/interview process. The policy has been updated 		

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	<p>event and interviews completed on 11/2/16 which paraphrased responses from staff the previous day. The "Comments/Explanation" indicated:</p> <p>-GHS (Group Home Staff) #8 indicated by "phone on 11/1/15 and then a written statement was completed by her on 11/2/15 according to [name of GHS #10's] written statement and in talking to her she witnessed the above mentioned staff being verbally abusive to [client #5]."</p> <p>-Client #3 was talked to in person on 11/1/15 at 11:05am and "also gave a written statement at that time. He states that he felt [name of GHS #20] was being bossy with him and that she was cussing a lot."</p> <p>-Discharged client #9 stated GHS #2 was "cussing and got in staff [name of GHS #10's] face after [name of GHS #10] asked her to please stop. She also stated that [GHS #20] stated at this point she hated her f----- job."</p> <p>-Client #5 stated that GHS #20 "was mean to her and cussed at her."</p> <p>The investigation did not include the questions asked, a summary of events, findings, corrective actions, and/or the actual written witness statements by the staff and clients interviewed during the investigation.</p> <p>-A 5/5/15 BDDS report for an incident on</p>		<p>accordingly. All clients involved or potentially involved will also be interviewed or represented during the investigatory process. This will occur no later than 06/26/2016.</p> <p>·All investigatory managers will be retrained on this policy and procedure before 06/26/2016.</p> <p>·The QDDP will review all allegations, interviews and action taken to ensure that the agency administrative staff identify allegations of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p>		

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	<p>4/29/15 at 12:00pm indicated the BDDS office "received a call from [Discharged Client #10's] mother/guardian. She stated that on Wednesday 4/29/15 [Discharged client #10] was left without staff while at swim practice. She went on to say that on the way over to swim practice, staff received a phone call stating that he had the med. (medication) room key and needed to return to the group home ASAP (As Soon As Possible). She stated that staff dropped [Discharged client #10] off at swim practice without letting Special Olympics staff know she did not have staff. [Discharged client #10] had the emergency cell phone for the van and called the house manager stating she was without staff." No investigation was available for review.</p> <p>-A 5/1/15 Follow Up report indicated Discharged Client #10 was "without staff, no more than 30 minutes. The staff reported he discussed with an off duty lifeguard to watch [discharged client #10], and this (sic) the lifeguard agreed." The follow up indicated "the results of the investigation: Results are that the staff was acting per the direction of a senior staff person to return the med. cart keys to the home for another client's insulin injection. The staff followed the direction to leave the consumer under the</p>						

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W 0225 Bldg. 00	<p>monitoring of another person. However [staff name] did not leave [Discharged client #10] with a Carey Services staff person who was trained on [Discharged client #10] (sic). Instead he left the consumer under the monitoring of an off duty lifeguard. This is not acceptable practice...Allegation Substantiated." No investigation was available for review.</p> <p>On 5/27/16 at 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated allegations were not thoroughly investigated. The QIDP indicated the 11/1/15 investigation paraphrased responses, questions were not available for review, and the investigation did not include witness statements, a summary, or corrective actions/results. The QIDP indicated Discharged client #10's incident of being left alone at swim practice was investigated, however no investigation was available for review.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 3 of 4 sampled clients</p>	W 0225	W225- "The comprehensive functional assessment must	06/10/2016			

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	<p>(clients #1, #2, and #4), the facility failed to assess clients #1, #2, and #4's vocational abilities related to their individual work history, work skills, and work interests for day services.</p> <p>Findings include:</p> <p>On 5/19/16 from 9:00am until 10:40am, clients #1, #2, and #4 were observed at the facility owned day services classroom. From 9:00am until 10:40am, clients #1, #2, and #4 colored on paper, completed word find puzzles in their books, and drank coffee.</p> <p>Client #1's record review was conducted on 5/20/16 at 10:20am. Client #1's 3/22/16 ISP (Individual Support Plan) and 3/22/16 "Yearly ISP Vocational/Life Skills Program Assessment Report" indicated it was "client choice" to attend "Life Skills Class," and "Recommendation for Voc Rehab (Vocation Rehabilitation) to obtain employment." Client #1's record did not include her work history, work skills, and/or work interests.</p> <p>Client #2's record review was conducted on 5/20/16 a 11:55am. Client #2's 3/22/16 ISP (Individual Support Plan) and 3/22/16 "Yearly ISP Vocational/Life Skills Program Assessment Report"</p>		<p>include, as applicable, vocational skills" The facility failed to assess clients #1, #2, and #4 's vocational abilities related to their individual work history, work skills, and work interests for day services. The correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·QDDP will update the Vocational Skills Assessment to include a section that focuses on work history, work skills, and work interests for each consumer. This has been completed on 06/10/2016. 		

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	<p>indicated it was "client choice" to attend "Life Skills Class," and "Recommendation for Voc Rehab to obtain employment. [Client #2] is very nurturing and would be good at something where she can help others." Client #2's record did not include her work history, work skills, and/or work interests.</p> <p>Client #4's record review was conducted on 5/20/16 at 12:15pm. Client #4's 3/22/16 ISP (Individual Support Plan) and 3/22/16 "Yearly ISP Vocational/Life Skills Program Assessment Report" indicated it was "client choice" to attend "Life Skills Class," and "Recommendation for Voc Rehab to obtain employment. [Client #4] would be interested in something that is more independently done instead of group." Client #4's record did not include his work history, work skills, and/or work interests.</p> <p>On 5/27/16 at 9:00am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients #1, #2, and #4 had their day services served at the agency owned workshop. The QIDP indicated clients #1, #2, and #4's vocational assessments and skills were not assessed for their vocational history,</p>			

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W 0249 Bldg. 00	<p>work skills, and work interests.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #2), the facility failed to implement client #2's ISP (Individual Support Plan) objectives and use informal opportunities to redirect client #2 regarding client #6's dressing skills when opportunities existed.</p> <p>Findings include:</p> <p>On 5/19/16 from 5:30am until 7:45am, client #2 was observed at the group home. From 6:15am until 6:45am, GHS (Group Home Staff) #3 was in the kitchen when client #2 redirected clients #1, #4, #5, and #6 how to fix each clients' breakfast, served coffee and drinks to other clients, and packed clients #1 and #4's lunch boxes. No redirection was observed. At 6:45am, client #6 walked</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 identified in the individual program plan.”</p> <p>The facility failed to implement client #2’s ISP objectives and use informal opportunities to redirect client #2 regarding client #6’s dressing skills when opportunities existed. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Staff will be retrained on active treatment and client redirection by 06/26/2016. <ul style="list-style-type: none"> ○ A post-test on active treatment will be completed by staff to show competency of the 	06/26/2016

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	<p>into the kitchen where client #2 stood finishing packing lunches, client #6 indicated she was wearing a pair of socks that did not match to work. At 6:45am, client #4 pointed to client #6's unmatched socks and shook his head. Client #2 began to put client #6's belt through the belt loops of client #6's oversized shorts. Client #2 looked down at client #6's unmatched socks and stated to client #6 "to change (her) socks." Client #6 did not move. Client #2 indicated to client #6 to change her socks and stated "You can't go to work like that." Client #6 stated "You're not my boss." Client #2 redirected client #6 again. Client #6 walked away from client #2 in the direction of her bedroom. Client #2 followed client #6 down the hallway and into client #6's bedroom and the door closed. No redirection was observed. At 7:00am, GHS (Group Home Staff) #3 walked down the hallway and entered client #6's bedroom and client #2 exited and returned to the kitchen.</p> <p>Client #2's record was reviewed on 5/20/16 at 11:55am. Client #2's 3/22/16 ISP (Individual Support Plan) had a training objective to follow direction from staff with no more than 3 verbal prompts. Client #2's record did not indicate a BSP (Behavior Support Plan).</p>		<p>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 QIDP during home visits 3 out of 5 days a week for one month. After one month QIDP and Director can review compliance and move to monthly observations if compliance has been met. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p>		

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W 0382 Bldg. 00	<p>On 5/27/16 at 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #2 did not have a BSP. The QIDP indicated clients should not redirect other clients in the group home. The QIDP indicated client #2 was a new admission to the facility and tried to be helpful and nurturing to other clients. The QIDP indicated staff should use formal and informal opportunities to teach clients the appropriate ways to interact with one another.</p> <p>9-3-4(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 1 additional client (client #8), the facility failed to ensure client #8's medications were kept secured when not being administered.</p> <p>Findings include:</p> <p>On 5/18/16 from 3:45pm until 6:30pm and on 5/19/16 from 5:30am until 7:45am, client #8's bedroom was located in the lower level of the group home and</p>	W 0382	<p>W382 – “The facility must keep all drugs and biologicals locked except when being prepared for administration.” The facility failed to ensure client #8's medications were kept secured when not being administered. The plan of correction for this tag is as follows: · Applicable staff will be retrained by the LPN or RN on how to secure medications when not being administered, as well as while they are administering medications and how to check for proper labeling no later than</p>	06/26/2016

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989		
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	<p>client #8's "Chlorhex Glu. Sol. (Chlorhexidine Gluconate Mouth and Throat Solution) 0.12% oral (medicated)" rinse used to treat Gingivitis (a gum disease that causes red, swollen, and easily bleeding gums), was kept stored in the lower level bathroom cabinet which was unlocked. On 5/19/16 at 6:25am, client #8 walked into the medication room, carrying his bottle of "Chlorhex Glu. Sol.," waved the bottle to GHS (Group Home Staff) #3, and indicated his bottle was empty. GHS #3 indicated she would obtain an additional bottle of Chlorhex solution and take to client #8 who returned to the basement. At 7:45am, client #8 sat in the lower level living room, client #8's new unsecured Chlorhex solution medication bottle sat on top of his sink in the lower level bathroom.</p> <p>On 5/20/16 at 11:00am, and on 5/27/16 at 9:00am, interviews with QIDP (Qualified Intellectual Disabilities Professional) were conducted. The QIDP indicated medications at the group home should be kept secured when not being administered. The QIDP indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 5/20/16 at 11:00am, a record review</p>		<p>06/26/2016. o 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 QIDP during home visits monthly. All levels will assure ongoing compliance.</p>		

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W 0391 Bldg. 00	<p>of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>On 5/20/16 at 11:00am, the facility's 12/16/15 "Medication Administration" policy indicated "...All medications administered by staff shall be stored under lock or attended by persons with authorized access...."</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 of 17 medications administered at the morning medication administration (client #3), the facility failed to ensure client #3's insulin had a medication label from the pharmacy.</p> <p>Findings include:</p> <p>On 5/19/16 at 6:07am, client #3 with GHS (Group Home Staff) #3 selected his lancet, poked his right index finger, and</p>	W 0391	<p>W391 – “The facility must remove from use drugcontainers with worn, illegible, or missing labels” The facility failed to ensurethat client #3’s insulin had a medication label from the pharmacy. The plan ofcorrection for this tag is as follows: · Applicable staffwill be retrained by the LPN or RN on how to secure medications when not beingadministered, as well as while they are administering medications and how tocheck for proper labeling no later than</p>	06/26/2016			

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	<p>placed the used lancet into the overflowing sharps container on the side of the medication cart. At 6:07am, client #3 with GHS #3 selected his unlabeled bottle of "Lantus" insulin, drew 20 units into a needle. At 6:07am, after administering the insulin, client #3 and GHS #3 both indicated client #3's Lantus insulin bottle did not have a pharmacy label on the bottle, a method to identify the bottle as belonging to client #3, or a date the bottle of insulin was opened.</p> <p>Client #3's record was reviewed on 5/20/16 at 11:10am. Client #3's 5/1/16 Physician's Orders indicated "Lantus Inj (Injection) 100ml (milliliters) inject 20 units twice day for Diabetes."</p> <p>On 5/20/16 at 8:30am, the agency's 12/16/15 policy and procedure for "Health and Safety Policy 7.12.3" indicated "Medication Administration By Staff...Administration of Parenteral (a form of administration into the body other than through the digestive tract or mouth) medications/injections: Parenteral medications/injections will be given only by the Program Nurse or designated staff that has been trained in that procedure by the Program Nurse or a Home Health Care Professional. Staff will adhere to Universal Precautions Procedures when administering</p>		<p>06/26/2016. o 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 QIDP during home visits monthly. All levels will assure ongoing compliance.</p>				

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W 0426 Bldg. 00	<p>injections."</p> <p>On 5/20/16 at 11:00am and on 5/27/16 at 9:00am, interview with the agency QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility followed the Medication Administration Core A/Core B training. The QIDP indicated each medication should have a label to identify the client name, a label for the directions of its use, and document the date when the medication was opened.</p> <p>On 5/20/16 at 11:00am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The training manual indicated each clients' medication should be dated when the medication was opened.</p> <p>9-3-6(a)</p> <p>483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review, and</p>	W 0426	W426 – "The facility must, in	06/26/2016

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	<p>interviews the facility failed for 8 of 8 clients who lived in the group home (clients #1, #2, #3, #4, #5, #6, #7, and #8) to ensure water temperatures did not exceed 110 degrees Fahrenheit and failed to implement the facility system to monitor hot water over 110 degrees.</p> <p>Findings include:</p> <p>On 5/18/16 from 3:45pm until 6:30pm and on 5/19/16 from 5:30am until 7:45am, observations and interview were conducted at the group home and the hot water temperature in the kitchen and bathrooms exceeded 110 degrees Fahrenheit. On 5/18/16 at 4:15pm, the kitchen hot water temperature was 114 degrees Fahrenheit. During both observation periods clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed in the group home, clients had access to hot water in the kitchen, hallway bathroom, bathrooms inside their private bedrooms, and were observed to enter/exit these areas independently without facility staff.</p> <p>On 5/19/16 at 6:08am, GHS (Group Home Staff) #3 stated the "hot water temperature fluctuated above 114 degrees Fahrenheit." GHS #3 stated the "last time the hot water was checked was 5/9/16 and was 113 degrees Fahrenheit." GHS #3 provided a written temperature</p>		<p>areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. The facility failed to ensure water temperatures did not exceed 110 degrees Fahrenheit and failed to implement the facility system to monitor hot water over 110 degrees. The plan of correction for these findings is as follows: · Water heater in the home has a mixing valve. The home is equipped with ceiling heat and is located next to the water piping in the ceiling. This causes a fluctuation in temperature of the water when it is first turned on. By October 2016 the home will have the ceiling heat removed and a heat pump put in to ensure that the water pipes are no longer being affected by the ceiling heat. Until then all consumers in the home are capable of mixing their own water to an appropriate temperature. Water Temperature assessments are attached to this plan of correction. Staff will be trained to monitor consumers mixing their water by 06/26/2016 until the heat pump can be put in place.</p> <p>· The home manager will assure compliance during routine group home observations, generally 5 out of every 7 days. After one month the QIDP and</p>				

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	<p>log which indicated on 5/9/16 the hot water temperature was "113 degrees" Fahrenheit. At 7:40am, GHS #1 and GHS #3 both stated the group home hot water temperature "exceeded 120" degrees Fahrenheit in the kitchen sink. At 7:40am, the hot water in the kitchen sink was 124 degrees Fahrenheit and then dropped to 120 degrees. GHS #1 and GHS #3 both indicated water temperatures should be under 110 degrees Fahrenheit and no maintenance notification had been made to adjust the water temperature. GHS #1 indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 needed their hot water regulated under 110 degrees Fahrenheit.</p> <p>Interviews were conducted with the Qualified Intellectual Disabilities Professional (QIDP) and the Residential Manager (RM) on 5/20/16 at 11:10am and on 5/27/16 at 9:00am, both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 could mix their water if provided an anti scald device on the hot water in the group home. The interviews indicated the anti scald device was to keep the hot water temperature below 110 degrees.</p> <p>Client #1's record review was conducted on 5/20/16 at 10:20am. Client #1's 3/22/16 ISP (Individual Support Plan) indicated "The individualized Support</p>		<p>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 QIDP, and Director, 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>Plan Team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how...Anti Scalding Devices, Carey Services has a mixing valve on the hot water heater at the group home to ensure that the water temperature does not exceed 110 degrees F (Fahrenheit)."</p> <p>Client #2's record review was conducted on 5/20/16 a 11:55am. Client #2's 3/22/16 ISP (Individual Support Plan) indicated "The individualized Support Plan Team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how...Anti Scalding Devices, Carey Services has a mixing valve on the hot water heater at the group home to ensure that the water temperature does not exceed 110 degrees F."</p> <p>Client #3's record review was conducted on 5/20/16 at 11:10am. Client #3's 3/22/16 ISP (Individual Support Plan) indicated "The individualized Support Plan Team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how...Anti Scalding Devices, Carey Services has a mixing valve on the hot water heater at the group home to ensure that the water temperature does not exceed 110 degrees F."</p>			

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W 0440 Bldg. 00	<p>Client #4's record review was conducted on 5/20/16 at 12:15pm. Client #4's 3/22/16 ISP (Individual Support Plan) indicated "The individualized Support Plan Team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how...Anti Scalding Devices, Carey Services has a mixing valve on the hot water heater at the group home to ensure that the water temperature does not exceed 110 degrees F."</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) living in the group home, the facility failed to conduct quarterly evacuation drills for the days (6:00am until 10:00am and 10:00am until 3:00pm) and the overnight (11:00pm until 8:00am) shifts of personnel.</p> <p>Findings include:</p> <p>On 5/18/16 at 3:45pm, a review of the facility's evacuation drills from 5/2015</p>	W 0440	<p>W440 – “The facility must hold evacuation drills at least quarterly for each shift of personnel.” The facility failed to conduct quarterly evacuation drills for the days and the overnight shifts of personnel. The plan of correction for these findings is as follows: · Staff will be retrained on the importance of holding fire drills no later than 06/26/2016.</p> <p>·The home manager will assure compliance during routine group home observations occurring each month in order to ensure that drills are being</p>	06/26/2016

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	<p>through 5/2016 was conducted. The review indicated the facility had failed to conduct the following evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8</p> <p>For the day shift of personnel (6:00am until 10:00am and 10:00am until 3:00pm) between 7/12/15 at 3:00pm and 1/22/16 at 6:45am. For the overnight shift of personnel (11:00pm until 8:00am) after 6/18/15 at 12:00am through 1/22/16 at 6:45am and from 1/22/16 at 6:45am until present 5/18/16.</p> <p>On 5/27/16 at 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the day shift of personnel was daily from 6:00am until 10:00am and from 10:00am until 3:00pm, and the night shift of personnel was daily from 11:00pm until 8:00am. The QIDP indicated no additional evacuation drills were available for review.</p> <p>9-3-7(a)</p>		<p>completed properly. After six months 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 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>· A drill schedule will be put into effect for staff to follow each month with a specific time to ensure that each shift is completing a fire drill per State regulations. Training on this schedule will occur no later than 06/26/2016.</p> <p>· The home manager will assure compliance during routine group home observations occurring each month in order to ensure that drills are being completed properly. After six months 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 and Chief Operations Officer during home visits</p>	

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W 0454 Bldg. 00	<p>483.470(I)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure the group home staff implemented sanitary methods for clients #1, #2, #3, #4, #5, #6, #7, and #8 to dispose of client #3's used needles that were overflowing on the unsecured medication cart.</p> <p>Findings include:</p> <p>On 5/18/16 from 3:45pm until 6:30pm and on 5/19/16 from 5:30am until 7:45am, observations and interviews were conducted at the group home. During both observation periods, the medication cart was kept inside the unsecured office at the group home and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked into and out of the unsecured area. Located on the side of the medication cart were unsecured sharp needles which were seen sticking out of</p>	W 0454	<p>monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p> <p>W454 – “The facility must provide a sanitary environment to avoid sources and transmissions of infections.”</p> <p>The facility failed to ensure the group home staff implemented sanitary methods for all clients and to dispose of client #3's used needles that were overflowing on the unsecured medication cart. The plan of correction for these findings is as follows: · Sharps container was replaced on 05/19/2016. · LPN will retrain staff on Infection Control Policy and this training will include and emphasize how to properly dispose of sharps and full sharps containers no later than 06/26/2016.</p> <p>· 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</p>	06/26/2016	

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	<p>the top of the sharps container. On 5/18/16 at 5:10pm, client #3 with GHS (Group Home Staff) #2, tested his blood sugar, poked a lancet (a sharp needle) into his left pinky finger. Client #3 uncapped the sharps container on the side of the medication cart, three (3) used recapped needles and two used uncapped lancets bounced onto the floor. Client #3 indicated he thought the needles and lancets were sharps he had used. Client #3 stated "I guess maybe [GHS #2] we'd better get a new container." Client #3 picked up the used sharps, recapped the needle he used for the injection, and pushed them down into the overflowing sharps container with his bare hands without redirection. At 5:10pm, client #3 with GHS #2 drew 16 units of Novolog insulin into one (1) needle and administered it to himself. After the injection client #3 recapped the used needle and placed it into the overflowing sharps container on the side of the medication cart.</p> <p>On 5/19/16 at 6:07am, client #3 with GHS #3 selected his lancet, poked his right index finger, placed the used lancet into the overflowing sharps container on the side of the medication cart. At 6:07am, client #3 with GHS #3 selected his unlabeled bottle of "Lantus" insulin, drew 20 units into a needle, selected his</p>		reevaluation will occur once again. Confirmation will occur by the QIDP, and Director, 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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(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>bottle of "Novolog" insulin drew 15 units into a second needle, and client #3 administered both injections with GHS #3 verbally prompting the injection sites to administer. After administering the insulin, client #3 recapped the needles, client #3 opened the overflowing sharps container on the side of the medication cart and the used recapped needles bounced out of the sharps container onto the floor. At 6:07am, client #3 and GHS #3 indicated needles were recapped for the safety of others.</p> <p>Client #3's record was reviewed on 5/20/16 at 11:10am. Client #3's 5/1/16 Physician's Orders indicated "Novolog Inj (Injection) 100ml (milliliters), inject 15units for Diabetes...(and) Novolog...per sliding scale as directed...Lantus Inj 100ml inject 20 units twice day for Diabetes."</p> <p>On 5/20/16 at 8:30am, the agency's 12/16/15 policy and procedure for "Health and Safety Policy 7.12.3" indicated "Medication Administration By Staff...Administration of Parenteral (a form of administration other than into the mouth or into the body's digestive tract) medications/injections: Parenteral medications/injections will be given only by the Program Nurse or designated staff that has been trained in that procedure by</p>				

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	<p>the Program Nurse or a Home Health Care Professional. Staff will adhere to Universal Precautions Procedures when administering injections...Health and Safety Policy 7.12.4...Disposable Sharps: Contaminated sharps are to be placed immediately or as soon as possible after use into appropriate sharps containers. Needles must not be recapped, bent or removed...The containers shall be maintained upright throughout use, replaced routinely and not be allowed to overflow."</p> <p>On 5/27/16 at 9:00am, the facility's 11/20/13 "Infection Control" policy and procedure indicated "Carey Services will provide a sanitary environment to avoid sources and transmission of infection."</p> <p>On 5/27/16 at 9:00am, the facility's 2004 "Living in the Community, Core A/Core B Medication Administration" training manual indicated "Universal precautions are the protective measures one would take to protect against the blood borne pathogens. These precautions must be used when coming to contact with another person's bodily fluids or handling personal care items that have bodily fluids on them. Staff should do the following to adhere to universal precautions:...properly dispose of contaminated materials exposed to blood</p>						

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	<p>or other bodily fluids...." The policy and procedure indicated used insulin needles were contaminated sharps.</p> <p>On 5/20/16 at 11:00am and on 5/27/16 at 9:00am, interview with the agency QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility staff failed to ensure used insulin needles and sharp objects were not recapped after use and to ensure the disposal of used needles and sharps correctly. The QIDP indicated the facility followed Core A/Core B medication training and Universal Precautions for the disposal of used sharps and needles. The QIDP indicated the sharps container should not have been overflowing and should have been discarded and replaced to ensure sharps were disposed of correctly.</p> <p>9-3-7(a)</p>			