

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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 investigation of complaint #IN00132710.</p> <p>Complaint #IN00132710: Substantiated. Federal and state deficiencies related to the allegation are cited at W102, W104, W122, W140, W149, W153, W154, W156, W159, W240, W312, W318, W331, W368, W381, W386, W454, W455, W473, W484 and W488.</p> <p>Dates of Survey: August 12, 13, 14, 15 and 20, 2013.</p> <p>Facility Number: 001116 Provider Number: 15G602 AIMS Number: 100245620</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/30/13 by Ruth Shackelford, QIDP.</p>	W000000		
---------	--	---------	--	--

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: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (A, B and C) and for 5 additional clients (D, E, F, G and H). The governing body failed: To ensure the staff immediately reported abuse, neglect and mistreatment to the administrator; to develop a system/policy and procedure which ensured the facility conducted complete and thorough investigations of all allegations of abuse/neglect/mistreatment/exploitation for clients A, B, C, D, E, F, G and H; to implement its policy and procedures to prevent potential neglect and/or abuse of clients to ensure a staff person, who had allegations of abuse/neglect and/or concerns in regard to resident care against them, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of neglect, abuse and/or mistreatment; to ensure clients A, B, C, D, E, F, G and H received health care services timely for their medical needs; to implement policies and procedures which prohibited client neglect, abuse, mistreatment and exploitation; to ensure the clients' home</p>	W000102	<p>ASI has policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to delay in reporting, the QIDP/Director were not able to conduct timely and thorough investigations. To address these issues, ASI has revamped it Incident Reporting process for all Group Homes. Any time an IR is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation. ASI has up-dated the report format of this document to ensure it is more complete. If an allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>was maintained and in good repair and to ensure clients' personal funds were not exploited.</p> <p>Findings include:</p> <p>1. Please refer to W122, the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), for the Governing Body's failure: __To ensure the staff immediately reported abuse, neglect and mistreatment to the administrator. __To develop a system/policy and procedure which ensured the facility conducted complete and thorough investigations of all allegations of abuse/neglect/mistreatment/exploitation for clients A, B, C, D, E, F, G and H. __To implement its policy and procedures to prevent potential neglect and/or abuse of clients to ensure a staff person, who had allegations of abuse/neglect and/or concerns in regard to resident care against them, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of neglect, abuse and/or mistreatment.</p> <p>2. Please see W318. The governing body failed to meet the Condition of Participation: Health Care Services for 3 of 3 sampled clients (clients A, B and C),</p>		<p>instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, they will email the Executive Director with the staff's name and brief description of the allegations. When the investigation is complete, a second email will be sent to the ED for him to ensure it is completed in a timely manner. This also ensures that the ED has been informed and is up-to-date on any allegations. This process will also be used for the QIDP to email the PD when an investigation is being done for consumer to consumer abuse and injury of unknown origin. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. For failing to ensure the clients' home was maintained and in good repair, ASI failed to monitor repairs needed to the home frequently enough. Site checks are now to be done weekly rather than monthly as was the prior procedure. This will ensure that concerns are identified and addressed in a more timely</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and 2 additional clients (clients G and H), by not ensuring clients received nursing services according to their medical needs: by failing to obtain physician ordered laboratory tests for client A; by failing to ensure client A had a plan for when she was to be out of the wheelchair; by failing to monitor and document the skin integrity of client A; by failing to ensure client B's weight loss was addressed and his record contained a desired weight range; by failing to have a fall risk plan for clients A, B and C; by failing to have a seizure protocol for clients A and H; by failing to ensure the MAR (Medication Administration Record) contain specific administration instructions for client A's Diazepam medication; by failing to have an updated dining plan for client A; by failing to obtain a follow-up podiatry appointment for client C and by failing to obtain timely medical intervention for clients G and H.</p> <p>3. Please refer to W104 for 3 of 3 sampled clients (A, B and C) and for 5 additional clients (D, E, F, G and H), the facility's Governing Body failed to exercise general policy and operating direction over the facility: __To ensure the facility implemented/developed its written policy and procedures to immediately report all allegations of abuse/neglect/mistreatment</p>		<p>manor. The site check forms are given to the Programming Coordinator to review and address any emergency issues. These are then reviewed at the bi-monthly safety committee meetings to ensure that the issues identified have been corrected/fixe. The system failed to ensure that consumers received health care services in a timely manner due to COC's not being entered consistently in to the database and appointments not being scheduled for follow up, or appointments being missed for various reasons and not rescheduled. To ensure that the nurse follows up on all COC's and appointments, this deficiency is being addressed as a nursing performance issue too. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed. The implementation of the Assistant Coordinators to assist the group homes in the monitoring and scheduling of doctor appointments and medical needs will address the COC's being immediately entered in to ASI's database and the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>to the administrator. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse/neglect/mistreatment/exploitation were thoroughly investigated.</p> <p>__ To ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse, neglect, exploitation and/or mistreatment.</p> <p>__ To ensure clients received timely medical care (clients G and H).</p> <p>__ To ensure the clients' home was maintained and in good repair (clients A, B, C, D, E, F, G and H).</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-1(a)</p>		<p>appointments being immediately scheduled. The Nursing Assistant will ensure that all regular appointments are scheduled for each consumer. Both the Assistants will report to the Nurse, Director of Programming and Quality Assurance Committee in regard to appointments scheduled for the month and any follow up needed. Additionally a shared calendar is in place in each county for appointment reminders to necessary staff. The system failed to ensure that consumer funds were not exploited. Previously, Leads in each home were responsible for balancing and managing consumer funds. Consumer funds were balanced and filed each month by the Leads. A thorough secondary check of consumer funds was lacking. ASI has implemented revised procedures for the management of consumer funds. Consumer money in the group home is counted and signed for by staff coming on shift at each shift. Any discrepancies in the balances from one shift to another are immediately reported to the Programming Coordinator and an investigation is completed. Monthly all consumer balance sheets and receipts are again reconciled by the Assistant Coordinator and signed off by the Programming Coordinator after they review it. Random financial audits are being conducted by</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>ASI's fiscal department monthly and report of findings sent to Quality Assurance for review. In response the letter dated Sept 17th, - Has there been any retraining of the staff on the new abuse/neglect/mistreatment/exploitation system? Staff have been retrained on the procedures for reporting an IR and the appropriate people to contact. QIDP, Programming Coordinator and Nurse have been retrained on the investigation process and the new form. Lists of names and numbers and a who do I call form is available in each home. In response to the questions - How is this being monitored? All IR"s are being brought in to the office each working day following the incident. A scanned copy of the incident is sent to the PC, QIDP and Nurse. Any IR's that were not immediately reported by a phone call will result in disciplinary action for the DSP. The QIDP, PC, and Nurse keep a call log of all calls taken. This call log is reviewed by the Director of Programming and Director of Administration weekly. Issue related to call logs are identified and addressed in weekly joint supervision meetings involving all counties ASI serves. These meetings involve trainings if needed and also information for staff meetings/ trainings. Site visitations by QIDP, PC, Assistant PC and Nurse will assist in monitoring issues with IR"s and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
			questions on the actual forms. These are done weekly. Both the Director of Programming and the Director of Administration conduct the Joint Supervision meetings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W000104	<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, interview and record review for 3 of 3 sampled clients (A, B and C) and for 5 additional clients (D, E, F, G and H), the facility's governing body failed to exercise general policy and operating direction over the facility: ___ To ensure the facility implemented/developed its written policy and procedures to immediately report all allegations of abuse/neglect/mistreatment to the administrator. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse/neglect/mistreatment/exploitation were thoroughly investigated, ___ To ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse, neglect, exploitation and/or mistreatment. ___ To ensure clients received timely medical care (clients G and H). ___ To ensure the clients' home was maintained and in good repair (clients A, B, C, D, E, F, G and H).</p>	W000104	<p>ASI has policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to delay in reporting, the QIDP/Director were not able to conduct timely and thorough investigations. To address these issues, ASI has revamped it Incident Reporting process for all Group Homes. Any time an IR is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation. ASI has up-dated the report format of this document to ensure it is more complete. If an allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings include:</p> <p>1. Observations were conducted in the group home on 08/12/13 from 4:00 PM until 5:20 PM and staff #1 and #2 were on duty. During a walk through of the home the following was observed:</p> <p>___ The wall behind the dining room table had 14 circular holes some the size of 1/4 inch; an area 1 1/2 inch by 1/2 inch without paint; an area 3 inches by 1/2 inch without paint.</p> <p>___ Above the base board by the front door was an area 36 inches long and 3 inches wide with holes in the dry wall.</p> <p>___ Eleven areas on the living room walls; 1 1/2 inches by 1/2 inch and an additional 5 areas 1 inch by 1/2 inch were missing paint.</p> <p>___ The living room wall to the right of the TV had paint off the wall in an area 12 inches by 6 inches and 2 inches by 10 inches.</p> <p>___ The corner wall going into the kitchen had an area on the lower wall by the base board 10 inches by 1 1/4 inch without plaster and the wall above the base board 36 inches by 3 inches without paint.</p> <p>An interview with staff #1 on 08/12/13 at 4:28 PM indicated the house was in need of repairs and she indicated administrative staff had walked through the house recently and was aware of the needed</p>		<p>instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, they will email the Executive Director with the staff's name and brief description of the allegations. When the investigation is complete, a second email will be sent to the ED for him to ensure it is completed in a timely manner. This also ensures that the ED has been informed and is up-to-date on any allegations. This process will also be used for the QIDP to email the PD when an investigation is being done for consumer to consumer abuse and injury of unknown origin. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. For failing to ensure the clients' home was maintained and in good repair, ASI failed to monitor repairs needed to the home frequently enough. Site checks are now to be done weekly rather than monthly as was the prior procedure. This will ensure that concerns are identified and addressed in a more timely</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>repairs.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility for clients A, B, C, D and F, to maintain an accurate accounting system for each client's individual personal fund accounts. Please see W140.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to: ___ Develop and implement written policies and procedures to ensure all allegations of abuse/neglect/injuries of unknown sources/exploitation were reported immediately to the administrator, were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within 5 working days from the date of knowledge of the abuse/neglect/exploitation. ___ Develop and implement written policies and procedures to ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse/neglect/exploitation/mistreatment. Please see W149.</p>		<p>manor. The site check forms are given to the Programming Coordinator to review and address any emergency issues. These are then reviewed at the bi-monthly safety committee meetings to ensure that the issues identified have been corrected/fixe. The system failed to ensure that consumers received health care services in a timely manner due to COC's not being entered consistently in to the database and appointments not being scheduled for follow up, or appointments being missed for various reasons and not rescheduled. To ensure that the nurse follows up on all COC's and appointments, this deficiency is being addressed as a nursing performance issue too. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed. The implementation of the Assistant Coordinators to assist the group homes in the monitoring and scheduling of doctor appointments and medical needs will address the COC's being immediately entered in to ASI's database and the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>4. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse, neglect, injuries of unknown sources and/or mistreatment were reported immediately to the administrator in accordance with state law for client C. Please see W153.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse/neglect/mistreatment/exploitation were thoroughly investigated for clients A, B, C, D, E, F, G and H. Please see W154.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse/neglect/injury of unknown source/mistreatment/exploitation were investigated and the results of the investigation reported to the administrator within 5 working days. Please see W156.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-1(a)</p>		<p>appointments being immediately scheduled. The Nursing Assistant will ensure that all regular appointments are scheduled for each consumer. Both the Assistants will report to the Nurse, Director of Programming and Quality Assurance Committee in regard to appointments scheduled for the month and any follow up needed. Additionally a shared calendar is in place in each county for appointment reminders to necessary staff. In response the letter dated Sept 17th, - Has there been any retraining of the staff on the new abuse/neglect/mistreatment/exploitation system? Staff have been retrained on the procedures for reporting an IR and the appropriate people to contact. QIDP, Programming Coordinator and Nurse have been retrained on the investigation process and the new form. Lists of names and numbers and a who do I call form is available in each home. In response to the questions - How is this being monitored? All IR"s are being brought in to the office each working day following the incident. A scanned copy of the incident is sent to the PC, QIDP and Nurse. Any IR's that were not immediately reported by a phone call will result in disciplinary action for the DSP. The QIDP, PC, and Nurse keep a call log of all calls taken. This call log is reviewed by the Director of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
			Programming and Director of Administration weekly. Issue related to call logs are identified and addressed in weekly joint supervision meetings involving all counties ASI serves. These meetings involve trainings if needed and also information for staff meetings/ trainings. Site visitations by QIDP, PC, Assistant PC and Nurse will assist in monitoring issues with IR"s and questions on the actual forms. These are done weekly. Both the Director of Programming and the Director of Administration conduct the Joint Supervision meetings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (A, B and C) and for 5 additional clients (D, E, F, G and H). The facility failed to implement its written policies and procedures:</p> <p>___ To prevent neglect/abuse/mistreatment/exploitation of clients A, B, C, D, E, F, G and H.</p> <p>___ To ensure all allegations of abuse/neglect/mistreatment/exploitation were thoroughly investigated.</p> <p>___ To ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse/neglect/exploitation/mistreatment.</p> <p>___ To ensure all allegations of abuse were reported immediately to the administrator and in accordance with state law.</p> <p>___ To ensure the results of all investigations were reported to the administrator within 5 working days from the date of incident or allegation.</p> <p>Findings include:</p>	W000122	<p>ASI has policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The system failed in the instances cited in this W for a few reasons:</p> <p>1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to delay in reporting, the QIDP/Director were not able to conduct timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an IR is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation. ASI has up-dated the report format of this document to ensure it is more complete. If an allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure,</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>1. The facility failed for clients A, B, C, D and F to maintain an accurate accounting system for each client's individual personal fund accounts. Please see W140.</p> <p>2. The facility failed to: ___ Develop and implement written policies and procedures to ensure all allegations of abuse/neglect/injuries of unknown sources/exploitation were reported immediately to the administrator, were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within 5 working days from the date of knowledge of the abuse/neglect/exploitation. ___ Develop and implement written policies and procedures to ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse/neglect/exploitation/mistreatment. Please see W149.</p> <p>3. The facility failed to ensure all incidents of abuse, neglect, injuries of unknown sources and/or mistreatment were reported immediately to the administrator in accordance with state law</p>		<p>and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, they will email the Executive Director with the staff's name and brief description of the allegations. When the investigation is complete, a second email will be sent to the ED for him to ensure it is completed in a timely manner. This also ensures that the ED has been informed and is up-to-date on any allegations. This process will also be used for the QIDP to email the PD when an investigation is being done for consumer to consumer abuse and injury of unknown origin. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In response the letter dated Sept 17th, - Has there been any retraining of the staff on the new abuse/neglect/mistreatment/exploitation system? Staff have been retrained on the procedures for reporting an IR and the appropriate people to contact. QIDP, Programming Coordinator and Nurse have been retrained on the investigation process and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>for client C. Please see W153.</p> <p>4. The facility failed to ensure all incidents of abuse/neglect/mistreatment/exploitation were thoroughly investigated for clients A, B, C, D, E, F, G and H. Please see W154.</p> <p>5. The facility failed to ensure all incidents of abuse/neglect/injury of unknown source/mistreatment/exploitation were investigated and the results of the investigation reported to the administrator within 5 working days. Please see W156.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-2(a)</p>		<p>the new form. Lists of names and numbers and a who do I call form is available in each home. In response to the questions - How is this being monitored? All IR's are being brought in to the office each working day following the incident. A scanned copy of the incident is sent to the PC, QIDP and Nurse. Any IR's that were not immediately reported by a phone call will result in disciplinary action for the DSP. The QIDP, PC, and Nurse keep a call log of all calls taken. This call log is reviewed by the Director of Programming and Director of Administration weekly. Issue related to call logs are identified and addressed in weekly joint supervision meetings involving all counties ASI serves. These meetings involve trainings if needed and also information for staff meetings/ trainings. Site visitations by QIDP, PC, Assistant PC and Nurse will assist in monitoring issues with IR's and questions on the actual forms. These are done weekly. Both the Director of Programming and the Director of Administration conduct the Joint Supervision meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000140	<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.</p> <p>Based on record review and interview, for 3 of 3 sample clients (clients A, B and C), and 2 additional clients (clients D and F), the facility failed to maintain an accurate accounting system for each client's individual personal fund account.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>07/26/13: "[QIDP (Qualified Intellectual Disabilities Professional)] received a phone call from [name], guardian of [client D]. He reported that he had received a phone call from [bank] at [address]. He was told that an individual tried to cash two checks of [client D's]. The incident occurred at the banks drive thru. The female in the car sent the two checks, a piece of paper with [client D's] Social Security number written on it, and [client D's] State ID (Identification) to the teller. After the teller asked the</p>	W000140	The system failed to ensure that consumer funds were not exploited. Previously, Leads in each home were responsible for balancing and managing consumer funds. Consumer funds were balanced and filed each month by the Leads. A thorough secondary check of consumer funds was lacking. ASI has implemented revised procedures for the management of consumer funds. Consumer money in the group home is counted and signed for by staff coming on shift at each shift. Any discrepancies in the balances from one shift to another are immediately reported to the Programming Coordinator and an investigation is completed. Monthly all consumer balance sheets and receipts are again reconciled by the Assistant Coordinator and signed off by the Programming Coordinator after they review it. Random financial audits are being conducted by ASI's fiscal department monthly and report of findings sent to Quality Assurance for review.	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>individual where [client D] was and was told (the teller) that she (client D) was at a dentist appointment. The teller returned the checks, ID and paper with [client D's] Social Security number on it. The agency suspended [Team Lead] as she was in possession of two endorsed checks for [client D] ([client D] is not able to sign her name). The agency is investigating the incident."</p> <p>07/29/13: "Audit of [client A's] monthly home financial statement and cash on hand was conducted by Abilities Services, Inc. on 7-29-13. The beginning July financial ledger states that [client A] should have \$39.63 in cash. There have been no debits for the month. Her bank bag contained \$.98. [Client A] is short \$38.65...conducting an investigation."</p> <p>07/29/13: "Audit of [client B's] monthly home financial statement and cash on hand was conducted by Abilities Services, Inc. on 7-29-13. The beginning July financial ledger states that [client B] should have \$33.44 in cash. There have been no debits for the month. His bank bag contained \$3.44. [Client B] is short \$30.00...conducting an investigation."</p> <p>08/07/13: Follow-up BDDS reports for clients A and B indicated the agency was reimbursing the missing money for clients</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>A and B.</p> <p>On 08/13/13 at 4:13 PM client C's personal funds accounts were reviewed with the Program Coordinator (PC). Client C's current petty cash balance ledger indicated client C had a balance of \$41.48. A money count with the PC indicated client C had \$40.48. Client C's petty cash funds were off a total of \$1.00. The PC indicated client C's funds did not balance.</p> <p>On 08/13/13 at 4:13 PM client F's personal funds accounts were reviewed with the Program Coordinator (PC). Client F's current petty cash balance ledger indicated client F had a balance of \$3.16. A money count with the PC indicated client F had \$2.16. Client F's petty cash funds were off a total of \$1.00. The PC indicated client F's funds did not balance.</p> <p>Client A's records were reviewed on 08/13/13 at 1:35 PM. Client A's Individual Support Plan (ISP) dated 09/13/12 indicated client A was not able to independently handle her money and required assistance.</p> <p>Client B's records were reviewed on 08/13/13 at 2:45 PM. Client B's ISP dated 04/19/13 indicated client B was not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>able to independently handle his money and required assistance.</p> <p>Client C's records were reviewed on 08/13/13 at 3:45 PM. Client C's ISP dated 11/09/12 indicated client C was not able to independently handle her money and required assistance.</p> <p>Client D's records were reviewed on 08/13/13 at 4:00 PM. Client D's ISP dated 01/17/13 indicated client D was not able to independently handle her money and required assistance.</p> <p>Client F's records were reviewed on 08/13/13 at 4:45 PM. Client F's ISP dated 04/20/13 indicated client F was not able to independently handle his money and required assistance.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated the agency was responsible for assisting clients A, B, C, D and F with their funds as they were not independent with their money and required assistance. She indicated the staff who tried to cash client D's checks had been terminated and the police were involved. She also indicated the accounting department had audited all the clients' accounts and had reimbursed those that had missing funds. She</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated the agency was currently reviewing their policy for management of client funds.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 3 of 3 sample clients (A, B and C) and 5 additional clients (D, E, F, G and H): The facility neglected to:</p> <p>__ Develop and implement written policies and procedures to ensure all allegations of abuse/neglect/exploitation were reported immediately to the administrator, were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within 5 working days from the date of knowledge of the abuse/neglect/exploitation.</p> <p>__ Develop and implement written policies and procedures to ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse/neglect/exploitation/mistreatment.</p> <p>__ Ensure client H received timely medical intervention for his medical condition.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review</p>	W000149	<p>ASI has policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The system failed in the instances sited in this W for a few reasons:</p> <p>1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to delay in reporting, the QIDP/Director were not able to conduct timely and thorough investigations. To address these issues, ASI has revamped it Incident Reporting process for all Group Homes. Any time an IR is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation. ASI has up-dated the report format of this document to ensure it is more complete. If an allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>05/09/13: A BDDS report indicated, "[Client H] had been discharged from [hospital] this same day in late morning. He went back to his Group Home. [Staff #6] notified Nurse stating [client H] was having a full blown seizure from head to toe shaking all over and stiffening up. [Staff #6] stated he is not responding to his or the other staff voice. Nurse, [name], instructed [staff #6] to call 911. Paramedics are (sic) Nurse arrived at the Group Home. Noted [client H] unresponsive to verbal and tactile stimuli. Bilateral extremities very stiff. Paramedics took to [hospital] ER (Emergency Room). From there, [client H] was transferred back to [hospital] on [address] where he is in ICU (Intensive Care Unit)." There was no investigation to indicate why staff failed to call 911 first, before placing a call to the nurse when client H was unresponsive.</p> <p>06/07/13: A BDDS report indicated, "[Client C] was sitting at a table in the break room when she reached over and hit [dayservice client A] on the right arm. She then stood up and started pointing her finger when another consumer entered the</p>		<p>instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, they will email the Executive Director with the staff's name and brief description of the allegations. When the investigation is complete, a second email will be sent to the ED for him to ensure it is completed in a timely manner. This also ensures that the ED has been informed and is up-to-date on any allegations. This process will also be used for the QIDP to email the PD when an investigation is being done for consumer to consumer abuse and injury of unknown origin. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In response the letter dated Sept 17th, - Has there been any retraining of the staff on the new abuse/neglect/mistreatment/exploitation system? Staff have been retrained on the procedures for reporting an IR and the appropriate people to contact. QIDP, Programming Coordinator and Nurse have been retrained</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>room. [Client C] then shoved two staff then threw herself on the floor...[Client C] and [dayservice client A] were separated..." There was no investigation of the client to client abuse.</p> <p>06/17/13: A BDDS report indicated, "[Client C] told staff [staff #14] that her upper thigh hurt. [Staff #14] had [client C] go to the bathroom so she could look at her leg for injury. No apparent injury. [Staff #14] asked [client C] what hurt, [client C] pointed to her right leg. [Staff #14]...asked if it happened at home. [Client C] shook her head yes. [Client C] began smacking her upper leg. [Staff #14] asked her what she was doing. [Client C] said [staff #10] (sic). [Staff #14] asked what did she do [client C] said hit me..."</p> <p>An investigation dated 06/17/13 indicated the following information had been gathered:</p> <p>An undated written statement by staff #10 indicated client C had stated, "[Staff #10] hurt [Client C] hurt [staff #10] (sic)."</p> <p>An undated written statement by staff #15 indicated, "[Staff #10] didn't do anything all morning except pass meds. She's super lazy! Left her to clean the house, didn't do it. She left too. Didn't do any morning work, except eat food and sit on her butt. That is all." The investigation failed to indicate all staff and clients had</p>		<p>on the investigation process and the new form. Lists of names and numbers and a who do I call form is available in each home. In response to the questions - How is this being monitored? All IR"s are being brought in to the office each working day following the incident. A scanned copy of the incident is sent to the PC, QIDP and Nurse. Any IR's that were not immediately reported by a phone call will result in disciplinary action for the DSP. The QIDP, PC, and Nurse keep a call log of all calls taken. This call log is reviewed by the Director of Programming and Director of Administration weekly. Issue related to call logs are identified and addressed in weekly joint supervision meetings involving all counties ASI serves. These meetings involve trainings if needed and also information for staff meetings/ trainings. Site visitations by QIDP, PC, Assistant PC and Nurse will assist in monitoring issues with IR"s and questions on the actual forms. These are done weekly. Both the Director of Programming and the Director of Administration conduct the Joint Supervision meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>been interviewed.</p> <p>07/01/13: A BDDS report indicated, "On July 1st, 2013 staff [staff #3] and [staff #5] reported to the Director of Day and Placement Services [name], that they had reported a number of concerns about fellow employee [staff #10] to [name] Group Home Coordinator but nothing has happened. The concerns are as follows:</p> <ol style="list-style-type: none"> 1. Consumers are not able to watch the shows that they like as [staff #10] will tell the consumers they are not age appropriate. 2. [Staff #10] tells the consumers they will have to go to their rooms after letting off gas at the dinner table. 3. Not using portion scoops at meal times. 4. Not thoroughly cleaning a consumer thoroughly after a bowel movement. 5. Asking a consumer to move out of a recliner so that she [staff #10] can sit in the recliner. 6. Asking a consumer to bring her laundry. <p>Staff [staff #10] is currently suspended and Group Home Coordinator, [name], is suspended pending investigation into the allegations."</p> <p>The investigation contained the following information: An undated typed statement by the Group</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

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

	<p>Home Coordinator indicated, "[Staff #3] came to me the week of June 9th and told me about an incident with [staff #10]...She proceeded to tell me that one day between June 8th - 13th while consumer [client H] was laying on the couch [staff #10] sat [client C] on the end of the couch at [client H's] feet and then proceeded to sit in the recliner. At one point [staff #10] got up to use the restroom, [staff #3] helped [client C] to the recliner. [Staff #3] said when [staff #10] came out from the restroom she looked at [client C] and said [client C] you stole my seat, I was sitting here first...Her [staff #3's] main issue with the incident was that the recliner belonged to the consumers in the home and staff should not sit down in them until all consumers have a seat first...This did not seem to be a case of ANE (Abuse - Neglect - Exploitation) so I told [staff #3] I would speak with [staff #10]..." The investigation failed to indicate all staff and clients had been interviewed.</p> <p>A typed statement by staff #3 indicated, "On July 16th at 9:00 am (June 16), the start of my shift as I was walking in [staff #2] stopped at the door to inform me that I would be upset and when I walked inside [client E] asked if he could get dressed as he was sitting on the couch in a pajama shirt with no buttons and pajama</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>bottoms that did not fit and would not snap. Immediately after [client E] had said this [staff #10] yelled from the kitchen where she was sitting at the bar 'I already dressed you [client E] you're fine.' My response was '[staff #10] there aren't any buttons on his shirt and his pants will not snap' and her reply was 'Than (sic) why were they in his room, we're not changing we're staying in our pajamas today!' I then walked over to the phone, clocked in and walked [client E] to his room to change...When I returned to the living room with [client E] he asked to sit in the empty recliner with [client C] in the one across from him which he did. The next thing I witnessed was [staff #10] demanding [client C] to get out of the recliner and move to the couch, so as she would have the recliner for herself. (an act she had committed everytime I work with her). [Client F] then approached me (sic) asked if he could speak with me and at this time he informed me that [staff #10] had made him do laundry again and she signed her signature afterwards and continued to do so for the rest of the day (sic). I then told [client F] he needed to speak with [Group Home Coordinator] on this matter. [Client F] would bring the basket to [staff #10] from the laundry room to the living room for her to fold and repeat for the rest of the day. Then I prepared lunch while watching other</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>consumers with [client D] helping me. When I had finished lunch I got the consumers who were up to the table, while [staff #10] continued to sit in the recliner where she had remained since the start of my shift. I then asked her if she would go get [client A] up for lunch and as she went to her room I noticed it was taking longer than what seemed to be a reasonable amount of time, so I walked to the hallway where I saw [staff #10] sitting on the toilet handing [client A] baby wipes as she was completely covered in feces sitting in her wheelchair. I walked back in because, the consumers could not be left alone and I had only checked to see what she was doing. She then brought [client A] to the table for lunch and after she showed she (client A) obviously didn't want to eat in the condition in which she was brought to the table by [staff #10]. I then took [client A] to the bathroom where I noticed she was still covered in her own feces and so I proceeded to give her a shower. Once completed with said shower I returned to the living room where [staff #10] was back in the recliner as per usual and so I continued to help the consumers clean up the mess left from lunch. While [client E] was sitting at the table he passed gas and said excuse me as he always does and [staff #10] yelled from the recliner, 'That's disgusting [client E] don't do that at the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>table, you do that again and you're going to your room!" I thanked [client E] for saying excuse me...Throughout the day she (staff #10) was still sitting in the recliner waiting to hear the timer in the laundry room go off and when it did she would yell for [client F] to get the laundry for her and [client F] continued to express that he didn't believe this was fair and I informed him he didn't have to, but as with all the consumers [client F] is afraid of her. While she continued to remain in the recliner [client E] would ask to go to the restroom she would pretend she didn't hear him or acknowledge him even as he continued to raise his volume and held himself (sic). I stopped what I was doing and took [client E] (a stand-by consumer) to the bathroom. [Client C] also asked to use the restroom at a later time and [staff #10] while still in the recliner and (sic) proceeded to tell [client C] (a line of site (sic) mind you) (line of sight = you must be able to see the client at all times) to go, while I was still assisting [client E] in the restroom. She had sent [client C] to the restroom while she remained in the recliner. (an act I have seen on numerous occasions). I asked [staff #10] if she could assist [client C] as I was still with [client E]. She wrote [client C] off as being dramatic and that [client C] was fine while she (staff #10) continued to yell from her recliner at</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
	[client C] to stop being dramatic. So, I was in the position of watching a stand-by and a line of sight alone. (another thing I have had to deal with on countless occasions). Keep in mind because the 3rd person on this weekend was pulled to waivers it was (sic) if I was working alone and that is being generous. When it was time for supper I continued to fix the meal by myself as she (staff #10) remained where she was the entire shift and when dinner was ready to be served she then got up and proceeded to the kitchen to fix their plates. She ignored the set serving sizes for the consumers so as she could make sure she got a ridiculous amount leaving the consumers with almost nothing and no leftovers. (This happens on more than a daily basis). On top of everything else that happened and taking care of the consumers by myself I was tasked with passing meds and at the time if (sic) the portions incident I was giving [client A's] 5:00 p.m. meds and unable to stop [staff #10] from eating all their food. There has not been any shift that I have ever worked with [staff #10] when she doesn't eat their food or sit on their recliners and leaves us to go off the menu with none of the food remaining to do it correctly...[Staff #10] never speaks in a appropriate manner (again my personal opinion) to the consumers, it's always yelling or ignoring them with [staff #10].			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>I feel this is why the consumers are intimidated or scared of her. Not to mention the fact that she never lets consumers watch what they would like to watch and even refuses them when they asked to watch something nicely. I have been to my direct supervisor with all of this on numerous occasions and the response I always get is either if we all (meaning employees) can't get along that she would lock us all in a room together where we could 'fight it out' or when I've told her [client C] says on a daily basis 'no [staff #10], [staff #10] hurt me; she responds that she isn't talking about [staff #10], but someone from long ago. [Client C] points at [staff #10] and says these things and the actions that I have witnessed from [staff #10] leads me to believe that [staff #10] is a threat to all consumers to the extent that on the weekends we work together I watch her very closely as I am afraid she will further compromise their safety. Thank You."</p> <p>A typed statement by staff #5 dated 06/27/13 indicated, "...A co-worker [staff #10]...since she has worked on my weekends she has yelled at consumers...telling them if they did not stop she would make them go to there (sic) room...I have personally seen [staff #10] put an incontinent consumer on the toilet with BM (bowel movement) all up</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the front and back and hand the consumer wipes to clean herself up, who is paralyzed (sic) on one side and in a wheelchair. [Staff #10] sits in a recliner durring (sic) or (sic) 12 hour shift and watches TV. She keeps the remote to where consumers (sic) and not watch what they like (sic)...Since we had a new consumer move into [group home] [staff #10] has been taking credit in doing laundry that she has had consumers doing the laundry...[Staff #10] has set (sic) consumers down who have walkers and move (sic) the walker across the room to where if they get up they did not have access to get them. [Staff #10] has put a fall risk and stand by assist consumer in the bathtub and did not stay in the bathroom with the consumer. If [staff #10] prepares a meal she will not use the portion scoops to make sure there is plenty left for her to eat...A consumer came to me asking if I had heard another house member say that [staff #10] hit her...I was not there to witness this but I feel that this consumer should be asked about this...I feel the consumer (sic) know things but are afraid or don't know how to voice what is going on...."</p> <p>A hand written statement by client F indicated, "On Monday June 17, 2013 [staff #10] telling me (sic) to take lunch box (sic) out to the van every morning it</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>is not my responsibility. I am tired of her telling me what to do and when she works on every other weekend she tells me to do the laundry that is not my responsibility I am tired of doing her work. I am only to do mine (sic) own laundry...She all (sic) so...tells [client C] to get out of the recliner and she all (sic) so hogs the TV and will not let know (sic) one watch the TV and yells at [client B] [client E] and [client C] and sits in the recliner and does nother (sic) and I ask (sic) her if I could put on a movie on the TV she said no and took over the TV and makes me put the washrags in the bathroom."</p> <p>A Follow-up BDDS report for the 07/01/13 incident dated 08/01/13 indicated, "The Coordinator [name] stated that she had never been told about any of the allegations against [staff #10] and was only told that [staff #10] was lazy. The Coordinator, [name] nor [staff #10] was found to be neglectful. There was no negative impact on any of the consumers in the home...[Staff #10] will be put on a different shift...."</p> <p>07/12/13: A BDDS report indicated, "[Client A] had finished her lunch and rolled up behind [dayservice client B] and hit her on the back of the neck. [Dayservice client B] had a red area. The two consumers were separated...." There</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>was no investigation of the client to client abuse.</p> <p>07/21/13: A BDDS report indicated, "07/21/13: "[Client C] was sleeping in bed when she was woken up at 1:00 AM to use the restroom. On the way to the restroom staff [staff #11] noticed a large (3 inch by 3 inch) black and purple bruise on the back of her right arm...Staff [staff #1] wrote a report on 7-21-13 at 10:15 AM that stated, 'Upon arriving to work a very large bruise on the back of [client C's] right arm in which was not there yesterday.' The report also notes that staff discovered another bruise coming up on the same arm. ([Client C] also has two dime size bruises and a nickel size bruise). Staff [staff #1] asked [client C] what happened and was initially told by [client C] that she fell out of bed. Then when asked additional times staff notes there was a different story as to what happened...."</p> <p>A Follow-up BDDS report to the 07/21/13 incident dated 08/01/13 indicated, "After talking to all staff at the home...it was determined that [client C] did not have the bruise on 7-20-13 when staff left at 10:00 PM. When staff left [client C] was in bed. The bruise was found on 7-21-13 at 1:00 AM when staff [staff #11] and [staff #6] were working. Both staff admitted to falling asleep</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>during their shift. It was concluded that [client C] had fallen out of her bed and staff was not initially aware due to sleeping...The two staff are receiving a written warning and will be subject to random checks to ensure they are awake for their entire shift." There was not indication the administrator was notified of the incident. The investigation failed to indicate all staff and clients had been interviewed.</p> <p>07/22/13: A BDDS report indicated, "Staff [staff #9] called [House Manager #1 (HM)] and informed her that [client G] was not feeling well. She stated that he had broke (sic) out in a cold sweat, was light headed and his blood pressure was 174/110. [HM #1] went to the group home to assess [client G] and called his mother. While speaking with [client G] he blacked out while sitting in the kitchen chair. [HM #1] advised [staff #3] to call 911. [Client G's] mother [name] arrived shortly after the EMTs (Emergency Medical Technicians). [Client G's mother] did state that the blood pressure was normal for [client G]. [Client G] told the EMTs he was having chest pain and numbness in his leg. EMTs advised the mother that they would be taken (sic) him to the hospital to be evaluated...." Client G did not receive timely medical intervention for his medical condition.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>07/26/13: A BDDS report indicated, "[QIDP (Qualified Intellectual Disabilities Professional)] received a phone call from [name], guardian of [client D]. He reported that he had received a phone call from [bank] at [address]. He was told that an individual tried to cash two checks of [client D's]. The incident occurred at the banks drive thru. The female in the car sent the two checks, a piece of paper with [client D's] Social Security number written on it, and [client D's] State ID (Identification) to the teller. After the teller asked the individual where [client D] was and was told (the teller) that she (client D) was at a dentist appointment. The teller returned the checks, ID and paper with [client D's] Social Security number on it. The agency suspended [Team Lead] as she was in possession of two endorsed checks for [client D] ([client D] is not able to sign her name). The agency is investigating the incident."</p> <p>07/29/13: A BDDS report indicated, "Audit of [client A's] monthly home financial statement and cash on hand was conducted by Abilities Services, Inc. on 7-29-13. The beginning July financial ledger states that [client A] should have \$39.63 in cash. There have been no debits for the month. Her bank bag contained \$.98. [Client A] is short</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>\$38.65...conducting an investigation."</p> <p>07/29/13: A BDDS report indicated, "Audit of [client B's] monthly home financial statement and cash on hand was conducted by Abilities Services, Inc. on 7-29-13. The beginning July financial ledger states that [client B] should have \$33.44 in cash. There have been no debits for the month. His bank bag contained \$3.44. [Client B] is short \$30.00...conducting an investigation."</p> <p>A Follow-up BDDS reports for the 07/29/13 incident dated 08/07/13 for clients A and B indicated the agency was reimbursing the missing money for clients A and B.</p> <p>07/29/13: A BDDS report indicated, "[Client D] was not able to sleep and was hitting the walls and screaming. After breakfast [client D] hit staff [staff #11] in the back several times. A little later [client C] kept trying to hit [client D] with her hand or walker. [Client C] did not make contact with [client D] but [client D] did hit [client C]. [Client C] and [client D] were separated...." There was no investigation available for review of this incident.</p> <p>08/02/13: A BDDS report indicated, "Staff [staff #9] reported to [name],</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>Director of Day and Placement Services that a consumer at [group home] told her that he woke up one night and there was a man at the group home with staff [staff #11] and when she saw consumer she told him to go back to bed. Staff has been suspended...." There was no investigation available for review of this incident.</p> <p>A review of the revised facility policy Abuse, Neglect and Exploitation dated 11/2009 was conducted on 08/14/13 at 2:30 PM. The policy indicated, "Verbal abuse: Any yelling, cursing, screaming, threatening, etc., language directed toward any consumer. Physical abuse: Any hitting, slapping, kicking, biting, throwing at, etc., or attempting to do so, toward a consumer, toward a consumer emotional anguish (sic). Emotional Abuse: Any action toward a consumer with the intent or possible intent of causing the consumer emotional anguish. Neglect: Any action that places or potentially places a consumer in a position/situation that results in injury. Is also defined as the intentional withholding of the basic necessities of life. Exploitation: Intentionally taking advantage of a consumer of one's own or another's gain without regard to the welfare or well being of the consumer. Humiliation: Any attempt to embarrass, shame, disgrace, or dishonor the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>consumer. Retaliation: any revenge, vengeance, or retribution toward the consumer."</p> <p>The policy indicated "Abilities Services also sets forth procedures for staff to report all incidents or suspected incidents of abuse, neglect, exploitation, and violation of rights in accordance with all applicable rules, regulations, and laws. All staff of Abilities Services, Inc. are MANDATORY REPORTERS of observed or suspected abuse, neglect, and exploitation in accordance with Acts of 1979, P.L. 276, Section 55 which states: Any member of the staff of a medical or other public institution, school, or facility, or agency shall report any suspect case of abuse, neglect, or exploitation to the Adult Protective Services to the Child Protective Services. In addition a report will be filed with BDDS. Abilities Services further mandates that all consumers should be free from humiliation and retaliation."</p> <p>Review of the Investigation Protocol dated "December 2011, May 2013" on 08/14/13 at 2:30 PM indicated: ___ "All staff has the responsibility to report concerns. These concerns should be reported to the Director of Programming, or any Director. In the event staff does not know the appropriate</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>Director, he/she can report to their supervisor or daily administrative staff and be forwarded to the appropriate person. Reports should be made immediately, and in no more than 24 hours to ensure consumer safety. All allegations should be documented on an Incident Report."</p> <p>__ "The investigating Director or designee is also responsible for completing the BDDS report within 24 hours."</p> <p>__ The investigating Director, or designee, is expected to interview all relevant staff and consumers (either parties to or possible witnesses of) the alleged mistreatment...."</p> <p>__ "Allegations of Consumer to Consumer abuse/Neglect/Exploitation: All staff has the responsibility to report concerns via the incident Report system and referred to the appropriate supervisor. Investigations of consumer to consumer mistreatment can be investigated by any of the following: Groups Home Manager, Programming Coordinator, QDDP, or nurse...The investigating staff are also responsible for completing the BDDS report in a timely manner...."</p> <p>The facility Investigative Protocol failed to indicate the results of all investigations must be reported to the administrator or designated representative in accordance with State law within five working days</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>of the discovery of the abuse/neglect/injury of unknown origin.</p> <p>On 08/14/13 at 2:30 PM, a review of the facility's 08/2008 Policy on Group Home Abuse and Neglect indicated, "...Results of the investigation must be reported within 5 days...."</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated all reportable and investigative records were provided for review. The PD stated client to client abuse was not investigated "unless there was a serious injury." The PD indicated the agency failed to follow the policy by failing to report incidents immediately to the administrator, by failing to investigate incidents, and by failing to investigate some of the incidents thoroughly and by failing to provide the investigative results to the administrator within 5 business days. The PD indicated their policy and procedures needed to be revised. The PD further indicated staff D had been terminated and staff #10 had been reassigned to a different location and staff #11 no longer worked for the agency. The PD indicated client H did not get timely medical intervention for his medical condition when he was unresponsive and staff should have called 911 before calling the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>nurse. Staff should have called 911 and not waited for a non-medical (HM #1) person to assess client G's condition. The PD indicated clients A, B, C, D, E, F and G all required 24 hour supervision, the two staff on duty should not have been sleeping and the clients should not have been unsupervised.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
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> <p>Based on record review and interview for 1 of 12 BDDS (Bureau of Developmental Disabilities Services) reports, the facility failed to report 1 of 1 injury of unknown source (client C) immediately to the Administrator in accordance with state law.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>07/21/13: A BDDS report indicated, "07/21/13: "[Client C] was sleeping in bed when she was woken up at 1:00 AM to use the restroom. On the way to the restroom staff [staff #11] noticed a large (3 inch by 3 inch) black and purple bruise on the back of her right arm...Staff [staff #1] wrote a report on 7-21-13 at 10:15 AM that stated, 'Upon arriving to work a very large bruise on the back of [client</p>	W000153	<p>ASI has policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to delay in reporting, the QIDP/Director were not able to conduct timely and thorough investigations. To address these issues, ASI has revamped it Incident Reporting process for all Group Homes. Any time an IR is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation. ASI has up-dated the report format of this document to ensure it is more complete. If an allegation involves staff abuse, the Director</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>C's] right arm in which was not there yesterday.' The report also notes that staff discovered another bruise coming up on the same arm. ([Client C] also has two dime size bruises and a nickel size bruise). Staff [staff #1] asked [client C] what happened and was initially told by [client C] that she fell out of bed. Then when asked additional times staff notes there was a different story as to what happened...."</p> <p>A Follow-up BDDS report to the 07/21/13 incident dated 08/01/13 indicated, "After talking to all staff at the home...it was determined that [client C] did not have the bruise on 7-20-13 when staff left at 10:00 PM. When staff left [client C] was in bed. The bruise was found on 7-21-13 at 1:00 AM when staff [staff #11] and [staff #6] were working. Both staff admitted to falling asleep during their shift. It was concluded that [client C] had fallen out of her bed and staff was not initially aware due to sleeping...The two staff are receiving a written warning and will be subject to random checks to ensure they are awake for their entire shift."</p> <p>The report did not indicate when the administrator was notified.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated the</p>		<p>is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, they will email the Executive Director with the staff's name and brief description of the allegations. When the investigation is complete, a second email will be sent to the ED for him to ensure it is completed in a timely manner. This also ensures that the ED has been informed and is up-to-date on any allegations. This process will also be used for the QIDP to email the PD when an investigation is being done for consumer to consumer abuse and injury of unknown origin. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In response the letter dated Sept 17th, - Has there been any retraining of the staff on the new abuse/neglect/mistreatment/exploitation system? Staff have been retrained on the procedures for reporting an IR and the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>administrator was to be notified immediately and there should be documentation to indicate the time of the notification. She indicated there was no way to know when the administrator was notified of the unknown injury.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-2(a)</p>		<p>appropriate people to contact. QIDP, Programming Coordinator and Nurse have been retrained on the investigation process and the new form. Lists of names and numbers and a who do I call form is available in each home. In response to the questions - How is this being monitored? All IR"s are being brought in to the office each working day following the incident. A scanned copy of the incident is sent to the PC, QIDP and Nurse. Any IR's that were not immediately reported by a phone call will result in disciplinary action for the DSP. The QIDP, PC, and Nurse keep a call log of all calls taken. This call log is reviewed by the Director of Programming and Director of Administration weekly. Issue related to call logs are identified and addressed in weekly joint supervision meetings involving all counties ASI serves. These meetings involve trainings if needed and also information for staff meetings/ trainings. Site visitations by QIDP, PC, Assistant PC and Nurse will assist in monitoring issues with IR"s and questions on the actual forms. These are done weekly. Both the Director of Programming and the Director of Administration conduct the Joint Supervision meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 3 of 3 allegations of client to client abuse for clients A, C and D), for 1 of 1 injury of unknown source for client C and for 2 allegations of abuse/neglect/mistreatment/harm for clients A, B, C, D, E, F, G and H, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>05/09/13: A BDDS report indicated, "[Client H] had been discharged from [hospital] this same day in late morning. He went back to his Group Home. [Staff #6] notified Nurse stating [client H] was having a full blown seizure from head to toe shaking all over and stiffening up. [Staff #6] stated he is not responding to his or the other staff voice. Nurse, [name], instructed [staff #6] to call 911.</p>	W000154	<p>ASI has policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to delay in reporting, the QIDP/Director were not able to conduct timely and thorough investigations. To address these issues, ASI has revamped it Incident Reporting process for all Group Homes. Any time an IR is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation. ASI has up-dated the report format of this document to ensure it is more complete. If an allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>Paramedics are (sic) Nurse arrived at the Group Home. Noted [client H] unresponsive to verbal and tactile stimuli. Bilateral extremities very stiff. Paramedics took to [hospital] ER (Emergency Room). From there, [client H] was transferred back to [hospital] on [address] where he is in ICU (Intensive Care Unit)." There was no investigation to indicate why staff failed to call 911 first, before placing a call to the nurse when client H was unresponsive.</p> <p>06/07/13: A BDDS report indicated, "[Client C] was sitting at a table in the break room when she reached over and hit [dayservice client A] on the right arm. She then stood up and started pointing her finger when another consumer entered the room. [Client C] then shoved two staff then threw herself on the floor...[Client C] and [dayservice client A] were separated..." There was no investigation available for review of this incident.</p> <p>06/17/13: A BDDS report indicated, "[Client C] told staff [staff #14] that her upper thigh hurt. [Staff #14] had [client C] go to the bathroom so she could look at her leg for injury. No apparent injury. [Staff #14] asked [client C] what hurt, [client C] pointed to her right leg. [Staff #14]...asked if it happened at home. [Client C] shook her head yes. [Client C]</p>		<p>instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, they will email the Executive Director with the staff's name and brief description of the allegations. When the investigation is complete, a second email will be sent to the ED for him to ensure it is completed in a timely manner. This also ensures that the ED has been informed and is up-to-date on any allegations. This process will also be used for the QIDP to email the PD when an investigation is being done for consumer to consumer abuse and injury of unknown origin. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In response the letter dated Sept 17th, - Has there been any retraining of the staff on the new abuse/neglect/mistreatment/exploitation system? Staff have been retrained on the procedures for reporting an IR and the appropriate people to contact. QIDP, Programming Coordinator and Nurse have been retrained</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>began smacking her upper leg. [Staff #14] asked her what she was doing. [Client C] said [staff #10] (sic). [Staff #14] asked what did she do [client C] said hit me..."</p> <p>An investigation dated 06/17/13 indicated the following information had been gathered:</p> <p>An undated written statement by staff #10 indicated client C had stated, "[Staff #10] hurt [Client C] hurt [staff #10] (sic)."</p> <p>An undated written statement by staff #15 indicated, "[Staff #10] didn't do anything all morning except pass meds. She's super lazy! Left her to clean the house, didn't do it. She left too. Didn't do any morning work, except eat food and sit on her butt. That is all." The investigation did not include any interviews from other clients in the home to indicate if they had witnessed client C's allegation against staff #10. The investigation failed to indicate all staff and clients had been interviewed.</p> <p>07/01/13: A BDDS report indicated, "On July 1st, 2013 staff [staff #3] and [staff #5] reported to the Director of Day and Placement Services [name], that they had reported a number of concerns about fellow employee [staff #10] to [name] Group Home Coordinator but nothing has happened. The concerns are as follows:</p> <ol style="list-style-type: none"> 1. Consumers are not able to watch the 		<p>on the investigation process and the new form. Lists of names and numbers and a who do I call form is available in each home. In response to the questions - How is this being monitored? All IR's are being brought in to the office each working day following the incident. A scanned copy of the incident is sent to the PC, QIDP and Nurse. Any IR's that were not immediately reported by a phone call will result in disciplinary action for the DSP. The QIDP, PC, and Nurse keep a call log of all calls taken. This call log is reviewed by the Director of Programming and Director of Administration weekly. Issue related to call logs are identified and addressed in weekly joint supervision meetings involving all counties ASI serves. These meetings involve trainings if needed and also information for staff meetings/ trainings. Site visitations by QIDP, PC, Assistant PC and Nurse will assist in monitoring issues with IR's and questions on the actual forms. These are done weekly. Both the Director of Programming and the Director of Administration conduct the Joint Supervision meetings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>shows that they like as [staff #10] will tell the consumers they are not age appropriate.</p> <p>2. [Staff #10] tells the consumers they will have to go to their rooms after letting off gas at the dinner table.</p> <p>3. Not using portion scoops at meal times.</p> <p>4. Not thoroughly cleaning a consumer thoroughly after a bowel movement.</p> <p>5. Asking a consumer to move out of a recliner so that she [staff #10] can sit in the recliner.</p> <p>6. Asking a consumer to bring her laundry.</p> <p>Staff [staff #10] is currently suspended and Group Home Coordinator, [name], is suspended pending investigation into the allegations."</p> <p>The investigation contained the following information: An undated typed statement by the Group Home Coordinator indicated, "[Staff #3] came to me the week of June 9th and told me about an incident with [staff #10]...She proceeded to tell me that one day between June 8th - 13th while consumer [client H] was laying on the couch [staff #10] sat [client C] on the end of the couch at [client H's] feet and then proceeded to sit in the recliner. At one point [staff #10] got up to use the restroom, [staff #3] helped [client C] to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the recliner. [Staff #3] said when [staff #10] came out from the restroom she looked at [client C] and said [client C] you stole my seat, I was sitting here first...Her [staff #3's] main issue with the incident was that the recliner belonged to the consumers in the home and staff should not sit down in them until all consumers have a seat first...This did not seem to be a case of ANE (Abuse - Neglect - Exploitation) so I told [staff #3] I would speak with [staff #10]...." The investigation was not thorough. The investigation failed to indicate all staff and clients had been interviewed.</p> <p>A typed statement by [staff #3] indicated, "On July 16th at 9:00 am (June 16), the start of my shift as I was walking in [staff #2] stopped at the door to inform me that I would be upset and when I walked inside [client E] asked if he could get dressed as he was sitting on the couch in a pajama shirt with no buttons and pajama bottoms that did not fit and would not snap. Immediately after [client E] had said this [staff #10] yelled from the kitchen where she was sitting at the bar 'I already dressed you [client E] you're fine.' My response was '[staff #10] there aren't any buttons on his shirt and his pants will not snap' and her reply was 'Than (sic) why were they in his room, we're not changing we're staying in our pajamas</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>today!' I then walked over to the phone, clocked in and walked [client E] to his room to change...When I returned to the living room with [client E] he asked to sit in the empty recliner with [client C] in the one across from him which he did. The next thing I witnessed was [staff #10] demanding [client C] to get out of the recliner and move to the couch, so as she would have the recliner for herself. (an act she had committed everytime I work with her). [Client F] then approached me asked if he could speak with me and at this time he informed me that [staff #10] had made him do laundry again and she signed her signature afterwards and continued to do so for the rest of the day (sic). I then told [client F] he needed to speak with [Group Home Coordinator] on this matter. [Client F] would bring the basket to [staff #10] from the laundry room to the living room for her to fold and repeat for the rest of the day. Then I prepared lunch while watching other consumers with [client D] helping me. When I had finished lunch I got the consumers who were up to the table, while [staff #10] continued to sit in the recliner where she had remained since the start of my shift. I then asked her if she would go get [client A] up for lunch and as she went to her room I noticed it was taking longer than what seemed to be a reasonable amount of time, so I walked to</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the hallway where I saw [staff #10] sitting on the toilet handing [client A] baby wipes as she was completely covered in feces sitting in her wheelchair. I walked back in because, the consumers could not be left alone and I had only checked to see what she was doing. She then brought [client A] to the table for lunch and after she showed she (client A) obviously didn't want to eat in the condition in which she was brought to the table by [staff #10]. I then took [client A] to the bathroom where I noticed she was still covered in her own feces and so I proceeded to give her a shower. Once completed with said shower I returned to the living room where [staff #10] was back in the recliner as per usual and so I continued to help the consumers clean up the mess left from lunch. While [client E] was sitting at the table he passed gas and said excuse me as he always does and [staff #10] yelled from the recliner, 'That's disgusting [client E] don't do that at the table, you do that again and you're going to your room!' I thanked [client E] for saying excuse me...Throughout the day she (staff #10) was still sitting in the recliner waiting to hear the timer in the laundry room go off and when it did she would yell for [client F] to get the laundry for her and [client F] continued to express that he didn't believe this was fair and I informed him he didn't have to, but as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with all the consumers [client F] is afraid of her. While she continued to remain in the recliner [client E] would ask to go to the restroom she would pretend she didn't hear him or acknowledge him even as he continued to raise his volume and held himself (sic). I stopped what I was doing and took [client E] (a stand-by consumer) to the bathroom. [Client C] also asked to use the restroom at a later time and [staff #10] while still in the recliner and (sic) proceeded to tell [client C] (a line of site (sic) mind you) (line of sight (sic) = you must be able to see the client at all times) to go, while I was still assisting [client E] in the restroom. She had sent [client C] to the restroom while she remained in the recliner. (an act I have seen on numerous occasions). I asked [staff #10] if she could assist [client C] as I was still with [client E]. She wrote [client C] off as being dramatic and that [client C] was fine while she (staff #10) continued to yell from her recliner at [client C] to stop being dramatic. So, I was in the position of watching a stand-by and a line of sight alone. (another thing I have had to deal with on countless occasions). Keep in mind because the 3rd person on this weekend was pulled to waivers it was (sic) if I was working alone and that is being generous. When it was time for supper I continued to fix the meal by myself as she (staff #10) remained			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>where she was the entire shift and when dinner was ready to be served she then got up and proceeded to the kitchen to fix their plates. She ignored the set serving sizes for the consumers so as she could make sure she got a ridiculous amount leaving the consumers with almost nothing and no leftovers. (This happens on more than a daily basis). On top of everything else that happened and taking care of the consumers by myself I was tasked with passing meds and at the time if (sic) the portions incident I was giving [client A's] 5:00 p.m. meds and unable to stop [staff #10] from eating all their food. There has not been any shift that I have ever worked with [staff #10] when she doesn't eat their food or sit on their recliners and leaves us to go off the menu with none of the food remaining to do it correctly...[Staff #10] never speaks in a appropriate manner (again my personal opinion) to the consumers, it's always yelling or ignoring them with [staff #10]. I feel this is why the consumers are intimidated or scared of her. Not to mention the fact that she never lets consumers watch what they would like to watch and even refuses them when they asked to watch something nicely. I have been to my direct supervisor with all of this on numerous occasions and the response I always get is either if we all (meaning employees) can't get along that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>she would lock us all in a room together where we could 'fight it out' or when I've told her [client C] says on a daily basis 'no [staff #10], [staff #10] hurt me; she responds that she isn't talking about [staff #10], but someone from long ago. [Client C] points at [staff #10] and says these things and the actions that I have witnessed from [staff #10] leads me to believe that [staff #10] is a threat to all consumers to the extent that on the weekends we work together I watch her very closely as I am afraid she will further compromise their safety. Thank You."</p> <p>A typed statement by staff #5 dated 06/27/13 indicated, "...A co-worker [staff #10]...since she has worked on my weekends she has yelled at consumers...telling them if they did not stop she would make them go to there (sic) room...I have personally seen [staff #10] put an incontinent consumer on the toilet with BM (bowel movement) all up the front and back and hand the consumer wipes to clean herself up, who is paralyzed (sic) on one side and in a wheelchair. [Staff #10] sits in a recliner during (sic) or (sic) 12 hour shift and watches TV. She keeps the remote to where consumers (sic) and not watch what they like (sic)...Since we had a new consumer move into [group home] [staff #10] has been taking credit in doing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>laundry that she has had consumers doing the laundry...[Staff #10] has set (sic) consumers down who have walkers and move (sic) the walker across the room to where if they get up they did not have access to get them. [Staff #10] has put a fall risk and stand by assist consumer in the bathtub and did not stay in the bathroom with the consumer. If [staff #10] prepares a meal she will not use the portion scoops to make sure there is plenty left for her to eat....A consumer came to me asking if I had heard another house member say that [staff #10] hit her...I was not there to witness this but I feel that this consumer should be asked about this...I feel the consumer (sic) know things but are afraid or don't know how to voice what is going on...."</p> <p>A hand written statement by client F indicated, "On Monday June 17, 2013 [staff #10] telling me (sic) to take lunch box (sic) out to the van every morning it is not my responsibility. I am tired of her telling me what to do and when she works on every other weekend she tells me to do the laundry that is not my responsibility I am tired of doing her work. I am only to do mine (sic) own laundry...She all (sic) so...tells [client C] to get out of the recliner and she all (sic) so hogs the TV and will not let know (sic) one watch the TV and yells at [client B] [client E] and</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>[client C] and sits in the recliner and does nother (sic) and I ask (sic) her if I could put on a movie on the TV she said no and took over the TV and makes me put the washrags in the bathroom."</p> <p>A Follow-up BDDS report for the 07/01/13 incident dated 08/01/13 indicated, "The Coordinator [name] stated that she had never been told about any of the allegations against [staff #10] and was only told that [staff #10] was lazy. The Coordinator, [name] nor [staff #10] was found to be neglectful. There was no negative impact on any of the consumers in the home...[Staff #10] will be put on a different shift..." The investigation did not include any interview from other clients in the home to indicate how they were treated by staff #10.</p> <p>07/12/13: A BDDS report indicated, "[Client A] had finished her lunch and rolled up behind [dayservice client B] and hit her on the back of the neck. [Dayservice client B] had a red area. The two consumers were separated..." There was no investigation available for review of this incident.</p> <p>07/21/13: A BDDS report indicated, "07/21/13: "[Client C] was sleeping in bed when she was woken up at 1:00 AM to use the restroom. On the way to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>restroom staff [staff #11] noticed a large (3 inch by 3 inch) black and purple bruise on the back of her right arm...Staff [staff #1] wrote a report on 7-21-13 at 10:15 AM that stated, 'Upon arriving to work a very large bruise on the back of [client C's] right arm in which was not there yesterday.' The report also notes that staff discovered another bruise coming up on the same arm. ([Client C] also has two dime size bruises and a nickel size bruise). Staff [staff #1] asked [client C] what happened and was initially told by [client C] that she fell out of bed. Then when asked additional times staff notes there was a different story as to what happened...."</p> <p>A Follow-up BDDS report to the 07/21/13 incident dated 08/01/13 indicated, "After talking to all staff at the home...it was determined that [client C] did not have the bruise on 7-20-13 when staff left at 10:00 PM. When staff left [client C] was in bed. The bruise was found on 7-21-13 at 1:00 AM when staff [staff #11] and [staff #6] were working. Both staff admitted to falling asleep during their shift. It was concluded that [client C] had fallen out of her bed and staff was not initially aware due to sleeping...The two staff are receiving a written warning and will be subject to random checks to ensure they are awake for their entire shift." The Investigation</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>did not include any interviews of the clients to indicate if they had heard anything that night. The investigation failed to indicate all staff and clients had been interviewed.</p> <p>07/29/13: A BDDS report indicated, "[Client D] was not able to sleep and was hitting the walls and screaming. After breakfast [client D] hit staff [staff #11] in the back several times. A little later [client C] kept trying to hit [client D] with her hand or walker. [Client C] did not make contact with [client D] but [client D] did hit [client C]. [Client C] and [client D] were separated...." There was no investigation available for review of this incident.</p> <p>08/02/13: A BDDS report indicated, "Staff [staff #9] reported to [name], Director of Day and Placement Services that a consumer at [group home] told her that he woke up one night and there was a man at the group home with staff [staff #11] and when she saw consumer she told him to go back to bed. Staff has been suspended...." There was no investigation available for review of this incident.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated some of the reportables lacked an investigation and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>some of the investigations that were present were not thorough. She indicated the agency did not investigate client to client aggression and they were in the process of changing that policy. The PD further indicated staff D had been terminated and staff #11 no longer worked for the agency.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 1 of 1 injury of unknown source (client C) and 1 of 1 incident of financial exploitation (client D), the facility failed to report the results of the investigations to the administrator within 5 working days from the date of incident.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>07/21/13: A BDDS report indicated, "[Client C] was sleeping in bed when she was woken up at 1:00 AM to use the restroom. On the way to the restroom staff [staff #11] noticed a large (3 inch by 3 inch) black and purple bruise on the back of her right arm...Staff [staff #1] wrote a report on 7-21-13 at 10:15 AM that stated, 'Upon arriving to work a very large bruise on the back of [client C's] right arm in which was not there</p>	W000156	<p>ASI has policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The system failed in the instances sited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to delay in reporting, the QIDP/Director were not able to conduct timely and thorough investigations. To address these issues, ASI has revamped it Incident Reporting process for all Group Homes. Any time an IR is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation. ASI has up-dated the report format of this document to ensure it is more complete. If an allegation involves staff abuse, the Director is notified and she/he initiates the</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>yesterday.' The report also notes that staff discovered another bruise coming up on the same arm. ([Client C] also has two dime size bruises and a nickel size bruise). Staff [staff #1] asked [client C] what happened and was initially told by [client C] that she fell out of bed. Then when asked additional times staff notes there was a different story as to what happened...."</p> <p>A Follow-up BDDS report to the 07/21/13 incident dated 08/01/13 indicated, "After talking to all staff at the home...it was determined that [client C] did not have the bruise on 7-20-13 when staff left at 10:00 PM. When staff left [client C] was in bed. The bruise was found on 7-21-13 at 1:00 AM when staff [staff #11] and [staff #6] were working. Both staff admitted to falling asleep during their shift. It was concluded that [client C] had fallen out of her bed and staff was not initially aware due to sleeping...The two staff are receiving a written warning and will be subject to random checks to ensure they are awake for their entire shift."</p> <p>The investigation was dated 07/29/13 by the Group Home Coordinator. The investigation was not signed by the administrator to indicate she had ever seen or reviewed the report.</p> <p>07/26/13: A BDDS report indicated,</p>		<p>investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, they will email the Executive Director with the staff's name and brief description of the allegations. When the investigation is complete, a second email will be sent to the ED for him to ensure it is completed in a timely manner. This also ensures that the ED has been informed and is up-to-date on any allegations. This process will also be used for the QIDP to email the PD when an investigation is being done for consumer to consumer abuse and injury of unknown origin. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In response the letter dated Sept 17th, - Has there been any retraining of the staff on the new abuse/neglect/mistreatment/exploitation system? Staff have been retrained on the procedures for reporting an IR and the appropriate people to contact.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>"[QIDP (Qualified Intellectual Disabilities Professional)] received a phone call from [name], guardian of [client D]. He reported that he had received a phone call from [bank] at [address]. He was told that an individual tried to cash two checks of [client D's]. The incident occurred at the banks drive thru. The female in the car sent the two checks, a piece of paper with [client D's] Social Security number written on it, and [client D's] State ID (Identification) to the teller. After the teller asked the individual where [client D] was and was told (the teller) that she (client D) was at a dentist appointment. The teller returned the checks, ID and paper with [client D's] Social Security number on it. The agency suspended [Team Lead] as she was in possession of two endorsed checks for [client D] ([client D] is not able to sign her name). The agency is investigating the incident." The investigation was dated 07/26/13 and was to be to the administrator by 08/02/13. The administrator did not sign the investigation until 08/05/13.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated the investigations were not signed by the administrator within the 5 days.</p> <p>This federal tag relates to complaint</p>		<p>QIDP, Programming Coordinator and Nurse have been retrained on the investigation process and the new form. Lists of names and numbers and a who do I call form is available in each home. In response to the questions - How is this being monitored? All IR"s are being brought in to the office each working day following the incident. A scanned copy of the incident is sent to the PC, QIDP and Nurse. Any IR's that were not immediately reported by a phone call will result in disciplinary action for the DSP. The QIDP, PC, and Nurse keep a call log of all calls taken. This call log is reviewed by the Director of Programming and Director of Administration weekly. Issue related to call logs are identified and addressed in weekly joint supervision meetings involving all counties ASI serves. These meetings involve trainings if needed and also information for staff meetings/ trainings. Site visitations by QIDP, PC, Assistant PC and Nurse will assist in monitoring issues with IR"s and questions on the actual forms. These are done weekly. Both the Director of Programming and the Director of Administration conduct the Joint Supervision meetings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
	#IN00132710. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed for 3 of 3 sampled clients (clients A, B and C): to ensure bed checks were conducted and documentation was completed; to ensure specific guidelines were in place to address ambulation needs for clients A, B and C and the Behavior Support Plan medications included a titration plan for clients B and C.</p> <p>Findings include:</p> <p>1. Client A's records were reviewed on 08/13/13 at 1:35 PM. Client A's Individual Support Plan (ISP) was dated 09/13/12 and indicated she required nightly assistance to the bathroom. Client A's record contained a "Bed Checks and Assistance to the Bathroom" document for the months of June, July and August 2013. The document indicated, "[client A] is to be checked on every 2 hours during sleeping hours, to see if she is sleeping, awake, or in any distress. She is gotten up and taken to the bathroom at 3:00 AM. Please use the following codes</p>	W000159	To address documentation of bed checks for consumers, staff have been retrained on the procedures of documentation. ASI has put in to place weekly quality control checks, performed by the Assistant Coordinator to ensure all tracking is being completed and is accurate compared to case notes. QIDP will receive a weekly summary from the Assistant to allow the QIDP to take appropriate action to ensure the tracking is completed. Quality Assurance will review and track issues with documentation to determine agency needs such as retraining or form modification. Additionally, ASI has implemented regular announced and unannounced site visits to be performed by professional staff including the QIDP, Programming Coordinators, Nurse, and Assistants. These visits will be documented and staff will have an outline of topics to review and check while in the home. These site visit forms will be forwarded to the Director of Programming for any immediate action needed based on visit. These visitations will be tracking by Quality Assurance Committee. Guidelines for ambulation needs is the responsibility of the nurse.	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>in the corresponding boxes to indicate what is occurring at the indicated times: Sleeping-S, Awake-AW, Dry-D, Wet-W. The document contained columns to track daily at 8 PM, 10 PM, 12 PM, 2 AM, 3 AM-up to bathroom, 4 AM, 6 AM and staff initials. The June 2013 check sheet did not contain any documentation to indicate the checks had been completed on 06/1, 2, 8, 13, 14, 15, 16, 22, 23 and 30/13. The July 2013 check sheet did not contain any documentation to indicate the checks has been completed on 07/3, 4, 5, 6, 14, 15, 16, 26, 27 and 29/13. The August 2013 check sheet did not contain any documentation to indicate the check had been completed on 08/1, 2, 3, 4, 8, 9, 10 and 11/13.</p> <p>2. Client B's records were reviewed on 08/13/13 at 2:45 PM. Client B's ISP dated 04/19/13 indicated client B required 24 hour supervision. Client B's record contained a "Bed Checks and Assistance to the Bathroom" document for the months of June, July and August 2013. The document indicated, "[client B] is to be checked on every 2 hours during sleeping hours, to see if he is sleeping, awake, or in any distress. Please use the following codes in the corresponding boxes to indicate what is occurring at the indicated times: Sleeping-S, Awake-AW, Dry-D, Wet-W. The document contained</p>		<p>ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed. Additionally, the consumer specific files will be checked weekly by the Assistant Coordinators to ensure that the identified needs medically have protocol and tracking in place. Review summaries will be forwarded to the Nurse for review and immediate action if needed. Quality Assurance will review findings to ensure issues have appropriate follow up. ASI contracts services for Behavioral Specialists. ASI has met with the Behavior Specialist to develop a plan to ensure that each individual taking psychotropic drugs are on a medication reduction plan. The Behavioral specialist will develop the BSP. Psychotropic medication will be monitored by the psychiatrist and behavioral data collected by the Nurse and QIDP. This information will be presented to the IDT quarterly, and noted in meeting notes for review by Director of Programming. Upon measurable improvement, the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>columns to track daily at 8 PM, 10 PM, 1 AM, 2 AM, 3 AM-up to bathroom, 4 AM, 6 AM and staff initials. The June 2013 check sheet did not contain any documentation to indicate the checks had been completed on 06/1, 8, 13, 14, 15, 21, 22, 23 and 25/13. The July 2013 check sheet did not contain any documentation to indicate the checks has been completed on 07/2, 3, 4, 5, 6, 10, 25, 26 and 27/13. The August 2013 check sheet did not contain any documentation to indicate the check had been completed on 08/1, 2, 3, 4, 8, 9, 10 and 11/13.</p> <p>3. Client C's records were reviewed on 08/13/13 at 3:45 PM. Client C's ISP dated 11/09/12 indicated client C required 24 hour supervision. Client C's record contained a "Bed Checks and Assistance to the Bathroom" document for the months of May, June and August 2013. The document indicated, "[client C] is to be checked on every 2 hours during sleeping hours, to see if she is sleeping, awake, or in any distress. She is gotten up and taken to the bathroom at 1:00 AM. Please use the following codes in the corresponding boxes to indicate what is occurring at the indicated times: Sleeping-S, Awake-AW, Dry-D, Wet-W. The document contained columns to track daily at 8 PM, 10 PM, 12 PM, 2 AM, 3 AM-up to bathroom, 4 AM, 6 AM and</p>		<p>team will consider making the appointment with he medical doctor to have a reduction in medication. The information will be presented by the QIDP or Nurse to HRC upon any change in psychotropic medications. The QIDP is responsible for presenting the information to HRC and leading the IDT meeting discussions.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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 initials. The May 2013 check sheet did not contain any documentation for 05/5, 8, 9, 10, 11, 12, 13, 17, 29, 20 and 31/13. The June 2013 check sheet did not contain any documentation to indicate the checks had been completed on 06/1, 2, 7, 8, 9, 14, 15, 16, 21, 22, 23 and 24/13. There was not a check sheet for the month of July 2013. The August 2013 check sheet did not contain any documentation to indicate the check had been completed on 08/1, 2, 3, 4, 8, 9, 10 and 11/13.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated clients A, B and C all required 24 hour supervision and the QIDP should be monitoring to ensure they were receiving their required supervision and care.</p> <p>2. Please refer to W240. The QIDP failed for 3 of 3 sampled clients (clients A, B and C) to ensure ambulation guidelines were present in the clients' plans.</p> <p>3. Please refer to W312. The QIDP failed for 2 of 3 sampled clients (clients B and C) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plan (BSP) included the medication or a titration plan for the medications in the plan.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>4. Please refer to W484. The QIDP failed for 1 of 3 sampled clients (client A) and 2 additional clients (clients D and F) to provide a full set of silverware for at meal time.</p> <p>5. Please refer to W488. The QIDP failed for 1 of 3 sampled clients (client A) and 2 additional clients (clients D and F), by not ensuring the client prepared their food as independently as possible.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated the house had recently gone through some staff changes in order to ensure things were correct and complete. The PD also indicated the QIDP needed to ensure staff were conducting and documenting bed checks.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-3(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (clients A, B and C) to specifically indicate in the clients' plans how staff were to monitor their wheelchair use and ambulation.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 08/12/13 from 4:00 PM until 5:20 PM and staff #1 and #2 were on duty. During the observation time client A used a wheelchair for mobility and clients B and C used walkers to assist with their mobility.</p> <p>Client A's records were reviewed on 08/13/13 at 1:35 PM. Client A's Individual Support Plan (ISP) was dated 09/13/12 and indicated her diagnoses included but were not limited to Severe Mental Retardation, Right eye blindness and Arthritis. A Continuity Of Care Form dated 03/11/13 indicated she was seen by PT (physical therapy) and OT (occupational therapy). The PT recommendation indicated, "...2. Stand with a walker, Goal increase...transfer</p>	W000240	<p>ASI failed to specifically indicate in the clients plan how staff were to monitor consumer wheelchair use and ambulation. Fall risk plans were not in place. This is the responsibility of the agency nurse and will be addressed as a performance issue. To prevent this from happening again, weekly reviews of medical files are done to ensure all protocol is up to date and in the consumers file to be tracked. All file audits information will be immediately reported to the nurse if information is missing. The director of programming will also be informed of any issues and will follow up with the nurse and the Quality Assurance Committee for any needed action. Quality Assurance will track use of protocols and any needed changes to assessments or tracking. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed. Adaptive</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>safety. 3. Lay flat in bed/recliner during the day." The OT recommendation indicated, "...might benefit from seeing w/c (wheelchair) seating specialist occasionally to make sure seating needs are being met."</p> <p>Client A's record did not contain a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client A.</p> <p>Client B's records were reviewed on 08/13/13 at 2:45 PM. Client B's ISP was dated 04/19/13 and indicated his diagnoses included but were not limited to Severe Mental Retardation, Legal blindness right eye and Parkinsonism (neurological syndrome). A Continuity Of Care Form dated 03/14/13 indicated client B was evaluated for his mobility needs. There were no new recommendations made by PT or OT. Client B's record did not contain a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client B and his mobility needs.</p> <p>Client C's records were reviewed on 08/13/13 at 3:45 PM. Client C's ISP was dated 11/09/12 and indicated her diagnoses included but were not limited to Profound Mental Retardation, Cerebral</p>		<p>Equipment checks previously were being performed weekly by the Nursing Assistant and or Lead of the Home. It has been changed to the Programming Assistant doing the adaptive equipment checks weekly and reporting to the Programming Coordinator to schedule any needed maintenance to the adaptive equipment. Bi-monthly safety committee is reviewing all adaptive equipment checklists for follow up to ensure all issues have been addressed and repairs have been completed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>Palsy and Arthritis. Her ISP indicated she had a PT evaluation on 01-15-2010 and a roller walker was ordered due to her falls. Her record did not indicated a reassessment was done after that time. Client C's record did not contain a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client C and her mobility needs.</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated clients A, B and C did not have current fall risk plans or ambulation plans specific to their mobility needs. She indicated clients A, B and C should have these plans in place to ensure staff knew how to care for and monitor their mobility needs.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients B and C) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plan (BSP) included the medication or a titration plan for the medications in the plan.</p> <p>Findings include:</p> <p>1. Client B's records were reviewed on 08/13/13 at 2:45 PM. Client B's BSP (Behavior Support Plan) dated 09/10/12 indicated client B's diagnosis included Oppositional Defiant Disorder and his behaviors included emotional outbursts. The BSP indicated client B was on Risperdal (antipsychotic) and Trazodone (antidepressant). The BSP indicated, "...Should [client B] demonstrate marked improvement in his emotional outbursts as evidenced by having 6 months free of them, the team may consider making an appointment with his MD to consider a reduction in the dosage of the medication</p>	W000312	<p>ASI has met with the Behavior Specialist to develop a plan to ensure that each individual taking psychotropic drugs are on a medication reduction plan. The Behavioral specialist will develop the BSP. Psychotropic medication will be monitored by the psychiatrist and behavioral data collected by the Nurse and QIDP. This information will be presented to the IDT quarterly, and noted in meeting notes for review by Director of Programming. Upon measurable improvement, the team will consider making the appointment with he medical doctor to have a reduction in medication. The information will be presented by the QIDP or Nurse to HRC upon any change in psychotropic medications. The QIDP is responsible for presenting the information to HRC and leading the IDT meeting discussions. All plans including psychotropic medications will be reviewed by HRC to ensure titration plans for those medications are in place and measurable.</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>that targets this behavior...." The BSP did not include a titration plan for the medication.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated client B's BSP should contain a titration plan.</p> <p>2. Client C's records were reviewed on 08/13/13 at 3:45 PM. Client C's BSP dated 10/19/12 indicated client C's behaviors included anxiety. The BSP indicated client C was on Zoloft for the anxiety. The BSP indicated, "...Should [client C] demonstrate marked improvement in her anxiety characteristics and impulsivity by having 6 months free of them, the team may consider making an appointment with her MD to consider the possibility of a reduction in the dosage of the medication that targets this behavior...." The BSP did not include a titration plan for the medication.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated client C's BSP should contain a titration plan.</p> <p>This federal tag relates to complaint #IN00132710.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
	9-3-5(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation of Health Care Services is not met as the facility failed for 3 of 3 sampled clients (clients A, B and C) and 4 additional clients (clients D, E, G and H) to ensure they received health care services for their medical needs.</p> <p>Findings include:</p> <p>1. Please refer to W331. The facility nursing services failed for 3 of 3 sampled clients (clients A, B and C), and 2 additional clients (clients G and H), by not ensuring clients received nursing services according to their medical needs: by failing to obtain physician ordered laboratory tests for client A; by failing to ensure client A had a plan for when she was to be out of the wheelchair; by failing to obtain a wheelchair reassessment for client A; by failing to monitor and document the skin integrity of client A; by failing to ensure client B's weight loss was addressed and his record contained a desired weight range; by failing to have a ambulation guidelines for clients A, B and C; by failing to have a seizure protocol for clients A and H; by failing to ensure the</p>	W000318	The system failed to ensure that consumers received health care services in a timely manner due to COC's not being entered consistently in to the database and appointments not being scheduled for follow up, or appointments being missed for various reasons and not rescheduled. To ensure that the nurse follows up on all COC's and appointments, this deficiency is being addressed as a nursing performance issue too. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed. The implementation of the Assistant Coordinators to assist the group homes in the monitoring and scheduling of doctor appointments and medical needs will address the COC's being immediately entered in to ASI's database and the appointments being immediately scheduled. The Nursing Assistant will ensure that all regular appointments are	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>MAR (Medication Administration Record) contained specific administration instructions for client A's Diazepam medication; by failing to have an updated dining plan for client A; by failing to obtain a follow-up podiatry appointment for client C and by failing to obtain timely medical intervention for clients G and H.</p> <p>2. Please refer to W368. The facility nursing services failed for 2 additional clients (clients E and G), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>3. Please refer to W381. The facility nursing services failed for 1 of 3 sampled clients (client A) who took a controlled substance medication prescribed by the physician, to ensure controlled substances were double locked.</p> <p>4. Please refer to W386. The facility nursing services failed for 1 of 3 sampled clients (client A) who took a controlled substance medication prescribed by the physician, to ensure periodic reconciliation of the medication.</p> <p>5. Please refer to W454. The facility nursing services failed for 2 of 3 sampled clients (clients A and C), to ensure a clean area for the clients to eat their meals.</p>		<p>scheduled for each consumer. Both the Assistants will report to the Nurse, Director of Programming and Quality Assurance Committee in regard to appointments scheduled for the month and any follow up needed. Additionally a shared calendar is in place in each county for appointment reminders to necessary staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>6. Please refer to W455. The facility nursing services failed to maintain proper hygiene practices for 2 of 3 sampled clients (clients A and C) who shared a comb.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients A, B and C), and 2 additional clients (clients G and H), by not ensuring clients received nursing services according to their medical needs: by failing to obtain physician ordered laboratory tests for client A; by failing to ensure client A had a plan for when she was to be out of the wheelchair; by failing to obtain a wheelchair reassessment for client A; by failing to monitor and document the skin integrity of client A; by failing to ensure client B's weight loss was addressed and his record contained a desired weight range; by failing to have an ambulation plan for clients A, B and C; by failing to have a seizure protocol for clients A and H; by failing to ensure the MAR (Medication Administration Record) contain specific administration instructions for client A's Diazepam medication; by failing to have an updated dining plan for client A; by failing to obtain a follow-up podiatry appointment for client C and by failing to obtain timely medical intervention for clients G and H.</p> <p>Findings include:</p>	W000331	The system failed to ensure that consumers received health care services in a timely manner due to COC's not being entered consistently in to the database and appointments not being scheduled for follow up, or appointments being missed for various reasons and not rescheduled. To ensure that the nurse follows up on all COC's and appointments, this deficiency is being addressed as a nursing performance issue too. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed. The implementation of the Assistant Coordinators to assist the group homes in the monitoring and scheduling of doctor appointments and medical needs will address the COC's being immediately entered in to ASI's database and the appointments being immediately scheduled. The Nursing Assistant will ensure that all regular appointments are	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>1. Client A's records were reviewed on 08/13/13 at 1:35 PM. Client A's Individual Support Plan (ISP) was dated 09/13/12 and indicated she used a wheelchair and her diagnoses included but were not limited to Severe Mental Retardation, Right eye blindness, seizures and Arthritis. Client A's record contained the following dated documents:</p> <p>Client A's record contained a fall risk evaluation completed quarterly and dated 10/30/12, 01/24/13, 04/24/13 and 07/31/13. The evaluation was based on a scoring system with a score of 10 or above indicating a "high risk" for falls. Client A's documented scores were all 10s which indicated she was at risk for falls. The record did not contain a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client A. Client A's record did not indicate the last time she had been fitted in that wheelchair or when she had originally received that chair. Client A's record did not contain guidelines when she should be in or out of her wheelchair.</p> <p>Client A's record contained Braden Scale - For Predicting Pressure Sore Risk completed quarterly and dated 10/24/12, 01/24/13, 04/24/13 and 07/31/13. The evaluation was based on a scoring system.</p>		<p>scheduled for each consumer. Both the Assistants will report to the Nurse, Director of Programming and Quality Assurance Committee in regard to appointments scheduled for the month and any follow up needed. Additionally a shared calendar is in place in each county for appointment reminders to necessary staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>Client A scored a 15 on all quarters which indicated she was at risk for pressure sores. The record did not contain a skin integrity check or how staff were to document and monitor her skin for breakdown.</p> <p>Client A's record contained an undated Seizure Protocol. The protocol did not include any information regarding client A's seizure type, medications or instructions as to what staff were to do when client A experienced a seizure. The record also contained an additional Seizure Protocol dated 01/09/12. The plan did not include client A's seizure medications, any instructions on documentation of the seizures and the plan was not updated.</p> <p>Client A's record contained an undated Dining Plan. The dining plan indicated she used her left hand and her right hand was not able to hold onto things. The plan indicated she was able to feed herself but did not indicate what utensils client A was able to use to feed herself.</p> <p>11/05/12: A Continuity Of Care Form indicated client A was seen by her neurologist for her seizures. The form indicated she was to have a Lamictal (seizures) level by April 2013. The record did not contain any documentation</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>to indicate the Lamictal level was obtained as ordered.</p> <p>03/11/13: A Continuity Of Care Form indicated she was seen by PT and OT. The PT recommendation indicated, "...2. Stand with a walker, Goal increase...transfer safety. 3. Lay flat in bed/recliner during the day." The OT recommendation indicated, "...might benefit from seeing w/c (wheelchair) seating specialist occasionally to make sure seating needs are being met." The record did not contain any documentation the recommendations were being completed.</p> <p>04/16/13: A Continuity Of Care Form indicated client A was seen for a routine 3 month check up with her physician. The form indicated she was to have a 3 month return visit on 07/23/13. The record did not contain any documentation to indicate the July 2013 visit had been completed as ordered.</p> <p>May 2013, June 2013, July 2013 and August 2013 Medication Administration Records (MARs) contained an order for: "Diazepam Gel 20 mg (milligram); Insert per rectum once as needed for seizures." The MAR did not indicate or define the "as needed" and specifically when staff were to administer the Diazepam.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client A did not have a have an updated and thorough seizure protocol or a fall risk plan and she was at risk for falls. She indicated client A was at risk for skin breakdown and there was no documentation to indicate her skin was being monitored. She also indicated there was no documentation to indicate the OT or PT recommendations had been addressed. The LPN indicated the record did not contain a follow-up appointment after the 4/16/13 order and there was not a record the Lamictal level was obtained as ordered. She indicated the MAR was not specific as to when to use the Diazepam Gel.</p> <p>2. Client B's records were reviewed on 08/13/13 at 2:45 PM. Client B's ISP was dated 04/19/13 and indicated he used a walker and his diagnoses included but were not limited to Severe Mental Retardation, Legal blindness right eye and Parkinsonism (neurological syndrome). Client B's record contained the following dated documents:</p> <p>Client B's record contained a fall risk evaluation completed quarterly and dated 10/30/12, 01/24/13, 04/24/13 and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>07/31/13. The evaluation was based on a scoring system with a score of 10 or above indicating a "high risk" for falls. Client B's documented scores were all 10s which indicated he was at risk for falls.</p> <p>03/14/13: A Continuity Of Care Form indicated client B was evaluated for his mobility needs. There were no new recommendations made by PT or OT. Client B's record did not contain a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client B and his mobility needs.</p> <p>A Vital Signs Flow Sheet recorded client B's weight as follows: 04/04/13: 103 05/04/13: 97 06/04/13: 98 07/04/13: 97 Client B's record did not contain any information on what his weight range was to be. The record did not contain any information that the weight loss had been addressed.</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client B was at risk for falls and did not have a fall risk plan. She also indicated there was no documentation to indicate what</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the weight range was for client B and the recent weight loss had not been addressed.</p> <p>3. Client C's records were reviewed on 08/13/13 at 3:45 PM. Client C's ISP was dated 11/09/12 and indicated she used a walker for ambulation and her diagnoses included but were not limited to Profound Mental Retardation, Cerebral Palsy and Arthritis. Her ISP indicated she had a PT evaluation on 01-15-2010 and a roller walker was ordered due to her falls. Her record did not indicate a reassessment was done after that time to indicate the roller walker was still the appropriate device to assist her with her ambulation needs.</p> <p>Client C's record contained a fall risk evaluation completed quarterly and dated 10/30/12, 01/24/13, 04/24/13 and 07/31/13. The evaluation was based on a scoring system with a score of 10 or above indicating a "high risk" for falls. Client C's documented scores were all 10s which indicated she was at risk for falls. The record did not contain a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client C.</p> <p>04/08/13: A Continuity Of Care Form</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated client C was seen for by the podiatrist and was to be seen again on 06/20/13. The record did not contain any documentation to indicate the June 2013 visit had been completed as ordered.</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client C was at risk for falls and did not have a fall risk plan. She also indicated there was no documentation to indicate the June 2013 podiatrist appointment was completed.</p> <p>4. Client G's records were reviewed on 08/14/13 at 2:45 PM. Client G's record contained the following dated documents:</p> <p>07/01/13: A Physical Examination indicated client G's blood pressure was 122/72.</p> <p>07/22/13: A BDDS (Bureau of Developmental Disabilities Services) report indicated the following: "Staff [staff #9] called [House Manager #1 (HM)] and informed her that [client G] was not feeling well. She stated that he had broke (sic) out in a cold sweat, was light headed and his blood pressure was 174/110. [HM #1] went to the group home to assess [client G] and called his mother. While speaking with [client G]</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>he blacked out while sitting in the kitchen chair. [HM #1] advised [staff #3] to call 911. [Client G's] mother [name] arrived shortly after the EMTs (Emergency Medical Technicians). [Client G's mother] did state that the blood pressure was normal for [client G]. [Client G] told the EMTs he was having chest pain and numbness in his leg. EMTs advised the mother that they would be taken (sic) him to the hospital to be evaluated...."</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client G failed to get timely medical intervention for his condition of sudden onset, which included his high blood pressure, sweating and complaints of being light headed. She indicated the HM #1 should not have delayed treatment by going to the house to see him. She indicated his blood pressure was higher than his normal and his symptoms warranted staff to call 911 prior to contacting the HM. She also indicated the nurse should be contacted for medical conditions.</p> <p>5. Client H's records were reviewed on 08/14/13 at 3:45 PM. Client H's record contained the following dated documents:</p> <p>05/02/13: A BDDS report indicated,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>"[Client H] had already gotten up for breakfast and start (sic) the day to go to Workshop. After he had eaten his breakfast, he went to take his dishes to the sink, and went down on his knees. [Client H] was complaining of a headache on the tope of his head...seemed a little unsteady while walking with his walker...notified nurse...PCP (primary care physician) instructed [staff #13] to take [client H] to the emergency room (ER) to get his shunt checked out...."</p> <p>05/09/13: A BDDS report indicated, "[Client H] had been discharged from [hospital] this same day in late morning. He went back to his Group Home. [Staff #6] notified Nurse stating [client H] was having a full blown seizure from head to toe shaking all over and stiffening up. [Staff #6] stated he is not responding to his or the other staff voice. Nurse, [name], instructed [staff #6] to call 911. Paramedics are (sic) Nurse arrived at the Group Home. Noted [client H] unresponsive to verbal and tactile stimuli. Bilateral extremities very stiff. Paramedics took to [hospital] ER. From there, [client H] was transferred back to [hospital] on [address] where he is in ICU (Intensive Care Unit)."</p> <p>06/13/13: A BDDS report indicated client H was discharged from the hospital</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>after his hospitalization from 05/09/13 - 06/08/13. The BDDS report indicated client H had a seizure on 05/09/13 and was taken to the hospital.</p> <p>Client H's record did not include a seizure care plan/protocol.</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client H did not have a history of seizures, had just been released from the hospital and staff failed to get timely medical intervention for his condition. She indicated [staff #6] should not have delayed treatment by calling the nurse. She indicated his symptoms warranted staff to call 911 prior to contacting her. She further indicated a seizure protocol was not in place when he was discharged back to the group home on 06/08/13.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 2 additional clients (clients E and G), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following medication errors:</p> <p>07/02/13: "Group home staff, [staff #4], who had passed medications in the AM on 7-2-13, did not being (sic) [client E's] Ocean Spray Nasal medication (for dry nasal passages) to the workshop to be dispensed on 7-2-13 at 11:00 AM. [Client E] did not receive his required dose."</p> <p>07/07/13: "[Pharmacy name] was sent a prescription on Tuesday (7-2-13) for [client G] for Daytrana (hyperactivity) 20 mg (milligram)/9 hr (hour) patch - Apply 1 patch daily. Daytrana patches were not</p>	W000368	<p>ASI failed to ensure that medications prescribed by the physician, were administered as ordered. ASI has medication administration procedures in place. These procedures have been reviewed and modified to state who is directly responsible for ensuring that all medications needed are available and that review of medications administered is being done regularly. A second check of meds administered in the home is being performed. Medication errors result in disciplinary action and med errors by staff are being tracked in a database to be reviewed by safety committee. Random med evals are being done in all group homes. Results of the med evals are sent to Director of Administration to ensure appropriate action is taken. Oversight of all meds administered is the responsibility of the Nurse. To ensure that the nurse follows up on all medications, this deficiency is being addressed as a nursing performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>received until Monday 7-8-13 at 3 PM, causing him to miss his patch on Sunday & Monday morning...."</p> <p>08/02/13: "Staff [staff #4] notified Coordinator [House Manager #2] that while administering [client G's] 7:00 AM medications on 8/3/13 she noted that the Fluoxetine HCL (hydrochloride) (antidepressant) 40 mg cap (capsule) Give 1 cap by mouth every day, was not given on 8/2/13. The medication was still in the bubble pack dated and initialed by responsible staff [staff #11]...."</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-6(a)</p>		<p>agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W000381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.</p> <p>Based on interview and record review, the facility failed for 1 of 3 sampled clients (client A) who took a controlled substance medication prescribed by the physician, to ensure controlled substances were double locked.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>06/03/13: "Staff [staff #3] called manager [House Manager #1] after arriving to her shift at 2:00 PM and counting controls that [client A] count (sic) for (Lorazepam 0.5 mg (milligram) 1 tablet by mouth as needed for seizures. May be given 12 hrs (hours) apart.) was 30 not 31 as stated on control sheet. Manager then contacted the nurse [name] to inform (sic) of the incident. [Nurse] went to the group home to check the count herself and found the count was off. All staff was (sic) immediately retrained by the nurse [name] at 8 AM 6/4/13 on the procedure of counting controls. Upon completion of</p>	W000381	<p>ASI has a policy and procedure in place to ensure safe storage of all controlled substances. To ensure that this is happening, ASI has implemented a review of all controlled substance forms. These forms are signed by staff at beginning and end of each shift ensuring the count of the controlled substance in correct. Upon an discrepancy in the count, the Nurse and Programming Coordinator and QIDP are contacted immediately. The Director of Programming is contacted if an investigation needs performed. The controlled substance sheets will also be checked in the site visits that are done by the Programming Coordinator, QIDP, Nurse, Nursing Assistant and Programming Assistant. The are being reviewed weekly in the file audit and any immediate action needed is reported the Nurse and Programming Coordinator. Safety committee reviews all reports of file audits regarding controlled substances along with Quality Assurance bi-monthly to identify any needed changes to procedures and or forms for tracking.</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the training they were then all sent for drug screens...."</p> <p>06/13/13: A Follow-up BDDS report for the incident indicated: "...Investigation is closed and no staff suspected of taking medication. Upon cleaning out the medication closet, the med[ication] in question was discovered under the fridge...."</p> <p>On 08/14/13 at 2:30 PM a review of the agency's 12/2012 policy and procedure on: "Monitoring Controlled Substances" was reviewed. The policy indicated, "1. All controlled substances are double-locked in the medication closets. The controlled substances are locked in a separate lock box then locked in a medication closet...."</p> <p>The U.S. Food and Drug Administration website was reviewed on 08/14/13 at 5:30 PM. The website indicated the drugs Lorazepam was a scheduled IV drug.</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the count was not accurate in the 06/03/13 incident because the medication was not accounted for. She further indicated it was at a later time the when medication was discovered on the floor and therefore</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>it was not kept secure and double locked.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000386	<p>483.460(l)(4) DRUG STORAGE AND RECORDKEEPING The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).</p> <p>Based on interview and record review, the facility failed for 1 of 3 sampled clients (client A) who took a controlled substance medication prescribed by the physician, to ensure periodic reconciliation of the medication.</p> <p>Findings include:</p> <p>On 08/12/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>06/03/13: "Staff [staff #3] called manager [House Manager #1] after arriving to her shift at 2:00 PM and counting controls that [client A] count (sic) for (Lorazepam 0.5 mg (milligram) 1 tablet by mouth as needed for seizures. May be given 12 hrs (hours) apart.) was 30 not 31 as stated on control sheet. Manager then contacted the nurse [name] to inform (sic) of the incident. [Nurse] went to the group home to check the county herself and found the</p>	W000386	<p>ASI has a policy and procedure in place to ensure safe storage of all controlled substances. To ensure that this is happening, ASI has implemented a review of all controlled substance forms. These forms are signed by staff at beginning and end of each shift ensuring the count of the controlled substance in correct. Upon an discrepancy in the count, the Nurse and Programming Coordinator and QIDP are contacted immediately. The Director of Programming is contacted if an investigation needs performed. The controlled substance sheets will also be checked in the site visits that are done by the Programming Coordinator, QIDP, Nurse, Nursing Assistant and Programming Assistant. The are being reviewed weekly in the file audit and any immediate action needed is reported the Nurse and Programming Coordinator. Safety committee reviews all reports of file audits regarding controlled substances along with Quality Assurance bi-monthly to identify any needed changes to procedures and or forms for</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>count was off. All staff was (sic) immediately retrained by the nurse [name] at 8 AM 6/4/13 on the procedure of counting controls. Upon completion of the training there were then all sent for drug screens...."</p> <p>06/13/13: A Follow-up BDDS report for the incident indicated: "...Investigation is closed and no staff suspected of taking medication. Upon cleaning out the medication closet, the med[ication] in question was discovered under the fridge...."</p> <p>On 08/13/13 at 11:00 AM a review of the August 2013 Medication Administration Record (MAR) Book was conducted. The MAR contained Narcotic Count Sheets for clients A, B and H who had narcotics prescribed by their physician and in the home. The count sheets contained the following information:</p> <p>For client A:</p> <p>Lorazepam 0.5 mg PRN (as needed) date received 06/07/13. The narcotic sheet indicated the Lorazepam was counted on the following days: 06/07, 11, 17, 18, 21, 22, 24, 26, 07/02, 05, 21, 08/02 and 08/04/13. The narcotic sheet indicated the medication was not counted on a daily basis.</p>		<p>tracking. Periodic reconciliation will take place weekly in file audit and medication review. The nurse is responsible for follow up to any findings. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>Diastat (for seizures) 20 mg date received 02/11/13. The narcotic sheet indicated the Diastat was counted on the following days: 02/11, 13, 16, 18, 19, 20, 21, 22, 23, 28, 03/01, 02, 04, 04/08, 06/11, 17, 21, 24, 07/02, 05, 08/04 and 08/10/13. The narcotic sheet indicated the medicine was not counted on a daily basis.</p> <p>For client B:</p> <p>Diazepam (for anxiety) 5 mg date received 05/31/13: The narcotic sheet indicated the Diazepam was counted on the following days: 05/31, 06/06, 07, 11, 17, 21, 24, 26, 07/02, 05, 08/02, 04 and 08/08/13. The narcotic sheet indicated the medicine was not counted on a daily basis.</p> <p>For client H:</p> <p>Temazepam (for sleep)15 mg date received 04/29/13: The narcotic sheet indicated the Temazepam was counted on the following days: 04/29, 30, 05/01, 06/02, 06, 07, 08, 09, 10, 11, 12, 13, 17, 21, 24, 26, 07/02, 05, 20, 21, 08/02 and 08/04/13. The narcotic sheet indicated the medicine was not counted on a daily basis.</p> <p>On 08/14/13 at 2:30 PM a review of the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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>agency's 12/2012 policy and procedure on: "Monitoring Controlled Substances" was reviewed. The policy indicated, "1. All controlled substances are double-locked in the medication closets. The controlled substances are locked in a separate lock box then locked in a medication closet. 2. All controlled substances are counted by ongoing and off-going staff at the beginning of each shift. There must be 2 staff members...counting the medications in each package of each consumer and comparing the total amount left of medication in the package of the Controlled Drug Record...3. The QDDP (Qualified Mental Retardation Professional), Medical Assistant and Nurse oversee the controlled drug records...6. All Controlled Drug Records will remain in the MAR together in chroncological (sic) order by date of the life of the medication."</p> <p>The U.S. Food and Drug Administration website was reviewed on 08/14/13 at 5:30 PM. The website indicated the drugs Lorazepam, Diastat and Diazepam were scheduled IV drugs and the Temazepam was a schedule III drug.</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>count was not accurate in the 06/03/13 incident because the medication was not accounted for. She further indicated it was at a later time the when medication was discovered on the floor and therefore it was not kept secure either. The LPN indicated the narcotics according to policy were to be counted daily by two staff, one coming on duty and one going off duty. She indicated the count should be accurate.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 2 of 3 sampled clients (clients A and C), the facility failed to ensure a clean area for the clients to eat their meals.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 08/12/13 from 4:00 PM until 5:20 PM and staff #1 and #2 were on duty. The dining room table was set with plates, napkins and spoons. At 4:35 PM staff #2 combed client C's hair and pulled it back from her face. Staff #2 laid the comb on the dining room table when she used a hair tie to pull client C's hair up. Staff #2 took the head band of client A from her head and laid it on the table. Staff #2 picked up the comb from the table and combed client A's hair, laid the comb back on the table and used a hair tie to pull client A's hair up. Staff #2 picked up the head band and placed it on client A's head. Additional dishes were placed on the dining room table for supper at 4:55 PM. Food was placed on the table at 5:02 PM. The dining room table was not cleaned after staff #2 placed hair items including a comb on the table.</p>	W000454	<p>Staff have been retrained on procedures for ensuring clients have a clean area to eat their meals. Universal Precautions are followed to ensure proper cleaning. Review of universal precautions will take place in the monthly staff meetings. Announced and unannounced visits will be made by professional staff weekly to allow meal times to be observed along with an outline of things to look for during these times. This will allow staff to ask questions and professional staff to immediately address any issues. Site Visitations forms are reviewed by safety and or quality assurance committee bi-monthly. Any immediate issues will be addressed on site. Tracking of issues will allow for discussion of whether or not procedures, policies, tracking needs changed or staff need retrained across the board or if additional training needs added.</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the hair items should not have been placed on the table and the table should have been cleaned prior to the plates and food being placed on the table.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-7(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed to maintain proper hygiene practices for 2 of 3 sampled clients (clients A and C) who shared a comb.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 08/12/13 from 4:00 PM until 5:20 PM and staff #1 and #2 were on duty. The dining room table was set with plates, napkins and spoons. At 4:35 PM staff #2 combed client C's hair and pulled it back from her face. Staff #2 laid the comb on the dining room table when she used a hair tie to pull client C's hair up. Staff #2 took the head band of client A from her head and laid it on the table. Staff #2 picked up the comb from the table and combed client A's hair, laid the comb back on the table and used a hair tie to pull client A's hair up. Staff #2 picked up the head band and placed it on client A's head. Additional dishes were placed on the dining room table for supper at 4:55 PM. Food was placed on the table at 5:02 PM. The dining room table was not cleaned after staff #2 placed hair items including a comb on the table.</p>	W000455	<p>Staff have been retrained on procedures for ensuring staff maintain proper hygiene practices for consumers Universal Precautions are followed. Review of universal precautions will take place in the monthly staff meetings. Announced and unannounced visits will be made by professional staff weekly at various times, to provide observation, along with an outline of things to look for during these times. This will allow staff to ask questions and professional staff to immediately address any issues. Site Visitations forms are reviewed by safety and or quality assurance committee bi-monthly. Any immediate issues will be addressed on site. Tracking of issues will allow for discussion of whether or not procedures, policies, tracking needs changed or staff need retrained across the board or if additional training needs added.</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the hair items should not have been placed on the table. She further indicated staff #2 should not have used the same comb for client A and C.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-7(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000473	<p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (clients A, B and C) and 3 additional clients (clients D, E and F) to ensure the meat was prepared and served at the correct temperature.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 08/12/13 from 4:00 PM until 5:20 PM and staff #1 and #2 were on duty. Staff #1 prepared the pork chops in the oven and at 5:02 PM placed the pork chops from the oven onto a serving plate and placed the plate on the dining room table. The plate of the pork chops was passed around the table to clients A, B, C, D, E and F and staff #1 and #2 placed the food on their plates. The pork was pink on the inside. At 5:08 PM client F stated his pork chop was a "little pink." An interview with staff #1 at 5:11 PM was conducted. She stated she had taken the "safe serve class" and pork was to be cooked to 140 degrees. She indicated she had checked the pork with a meat thermometer and it registered 140 degrees.</p>	W000473	<p>A meat thermometer is available in the home, temperatures for cooking of meat was not easily accessed on site. Now posted is temperature requirements for cooking meat and preparing and holding other food. Staff have been retrained on temperatures for cooking meat. Announced and unannounced visits will be made by professional staff weekly to allow meal times to be observed along with an outline of things to look for during these times. This will allow staff to ask questions and professional staff to immediately address any issues. Site Visitation forms are reviewed by safety and or quality assurance committee bi-monthly. Any immediate issues will be addressed on site. Tracking of issues will allow for discussion of whether or not procedures, policies, tracking needs changed or staff need retrained across the board or if additional training needs added.</p>	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>A record review of the facility "Use A Food Thermometer" pamphlet from the USDA (United States Department of Agriculture) Food Safety and Inspection Service was conducted on 08/13/13 at 1:30 PM. The pamphlet indicated, "Proper cooking is one of the four key steps for fighting BAC - bacteria that can be found in food." The pamphlet indicated the temperature of pork was to be at 160 degrees for medium and 170 degrees for well done.</p> <p>On 08/15/13 at 3:15 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the pork should have been prepared properly prior to eating. She indicated staff #1 was incorrect and the pork should have been at 160 degree to be cooked properly.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-8(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W000484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation, record review and interview the facility failed to provide a full set of silverware for 1 of 3 sampled clients (client A) and 2 additional clients (clients D and F) at meal time.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 08/12/13 from 4:00 PM until 5:20 PM and staff #1 and #2 were on duty. The supper menu included pork chops, baked potatoes and carrots. The table settings included plates, napkins, a glass and a spoon. There were no knives or forks at any of the table settings. At 5:01 PM client F was observed to use his fingers to get a baked potato from the serving bowl. A plate of pork chops was passed around the table by staff #1 and #2 who took a pork chop off the plate and placed it on the individual plates. At 5:08 PM staff #2 stated, "let's cut up some of this meat." Staff #2 cut client A's meat without her assistance. Staff #1 cut up clients D and F's meat without their assistance. At 5:11 PM client D was observed having difficulty using her</p>	W000484	<p>A full set of silverware was available at the group home for each consumer, however, staff did not set the table with all silverware. Staff have been retrained on procedures for each individual and their dining plan. Staff not following dining plans will receive disciplinary action. Regular review of dining plans will take place in monthly staff meetings. Announced and unannounced visits will be made by professional staff weekly to allow meal times to be observed along with an outline of things to look for during these times. This will allow staff to ask questions and professional staff to immediately address any issues. Site Visitation forms are reviewed by safety and or quality assurance committee bi-monthly. Any immediate issues will be addressed on site. Tracking of issues will allow for discussion of whether or not procedures, policies, tracking needs changed or staff need retrained across the board or if additional training needs added.</p>	09/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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>spoon it get the meat and/or carrots on to the spoon. At 5:13 PM client A was observed to be pushing the meat and carrots around the plate in an attempt to get them onto her spoon without success. An interview was conducted at 5:16 PM with staff #2. Staff #2 indicated all of the clients were able to feed themselves, were able to use forks and they would be able to cut meat with hand over hand assistance. When asked why forks and knives were not on the table she stated, "I don't know."</p> <p>Client A's records were reviewed on 08/13/13 at 1:35 PM. Client A's Comprehensive Functional Assessment (CFA) dated 09/11/12 indicated client A was was able to use a fork and spoon independently.</p> <p>Client D's records were reviewed on 08/13/13 at 4:00 PM. Client D's CFA dated 02/15/13 indicated client D was able to use a fork and spoon independently.</p> <p>Client F's records were reviewed on 08/13/13 at 4:45 PM. Client F's CFA dated 04/2013 indicated client F was able with to use a fork, knife and spoon independently.</p> <p>On 08/15/13 at 3:15 PM an interview</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>with the Program Director (PD) was conducted. The PD indicated the clients should have a full set of silverware.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>9-3-8(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client A) and 2 additional clients (clients D and F), by not ensuring the client prepared their food as independently as possible.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 08/12/13 from 4:00 PM until 5:20 PM and staff #1 and #2 were on duty. The supper menu included pork chops. The table settings included plates, napkins, a glass and a spoon. There were no knives or forks at any of the table settings. At 5:01 PM client F was observed to use his fingers to get a baked potato from the serving bowl. A plate of pork chops was passed around the table by staff #1 and #2 who took a pork chop off the plate and placed it on the individual plates. At 5:08 PM staff #2 stated, "let's cut up some of this meat." Staff #2 cut client A's meat without her assistance. Staff #1 cut up clients D and F's meat without their assistance. An interview was conducted at 5:16 PM with staff #2. Staff #2 indicated all of the</p>	W000488	All staff are trained on consumers dining plans. Staff have been retrained on procedures for each individual and their dining plan. Staff not following dining plans will receive disciplinary action. Regular review of dining plans will take place in monthly staff meetings. Announced and unannounced visits will be made by professional staff weekly to allow meal times to be observed along with an outline of things to look for during these times. This will allow staff to ask questions and professional staff to immediately address any issues. Site Visitation forms are reviewed by safety and or quality assurance committee bi-monthly. Any immediate issues will be addressed on site. Tracking of issues will allow for discussion of whether or not procedures, policies, tracking needs changed or staff need retrained across the board or if additional training needs added.	09/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>clients were able to use forks and they would be able to cut meat with hand over hand assistance. When asked why forks and knives were not on the table she stated, "I don't know."</p> <p>Client A's records were reviewed on 08/13/13 at 1:35 PM. Client A's Comprehensive Functional Assessment (CFA) dated 09/11/12 indicated client A was able with assistance to cut up food.</p> <p>Client D's records were reviewed on 08/13/13 at 4:00 PM. Client D's CFA dated 02/15/13 indicated client D was able with assistance to cut up food.</p> <p>Client F's records were reviewed on 08/13/13 at 4:45 PM. Client F's CFA dated 04/2013 indicated client F was able with assistance to cut up food.</p> <p>On 08/15/13 at 3:15 PM an interview with the Program Director (PD) was conducted. The PD indicated clients should prepare their food as independently as possible. She indicated clients A, D and F could have cut their own meat with assistance and staff should not have done that for them.</p> <p>This federal tag relates to complaint #IN00132710.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
	9-3-8(a)			