

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 10/08/2013
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 the PCR (post-certification revisit) to the investigation of complaint #IN00132710 completed on 08/20/13.</p> <p>Complaint #IN00132710: Not corrected.</p> <p>This survey was in conjunction to the pre-determined full annual recertification and state licensure survey which included the investigation of complaint #IN00137527.</p> <p>Dates of Survey: September 26, 27, 30 and October 1, 2, 3, 4 and 8, 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.</p> <p>Quality Review completed on 10/23/13 by W. Chris Greeney 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.

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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 interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), 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 ensure the facility immediately reported all allegations of abuse/neglect/mistreatment/exploitation and injuries of unknown source, to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and APS (Adult Protective Services) in accordance with state law and ___ To ensure all allegations of abuse/neglect/mistreatment/exploitation and injuries of unknown sources were thoroughly investigated.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility for 4 of 4 sample clients (A, B, C and D), and 3 additional clients (E, F and G) to ensure the facility developed and implemented written</p>	W000104	In response to W104, ASI failed to report and investigate alleged verbal abuse from one consumer to another. The statements were addressed with the consumer, and staff failed to identify these statements as verbal abuse. Staff have been re-trained that this is a reportable incident and requires an investigation per policy. All IR's are being reported to QIDP, PC, Nurse and PD. This will ensure no IR's are missed. QIDP, Nurse or PC will investigate consumer to consumer abuse following ASI procedures for investigation. PD will be notified that the investigation has started and will be contacted for review within 5 working days of the incident. All investigations will be reviewed by Administrative Director during this time period also. A review on incidents in safety committee bi-monthly meeting will provide oversight of reportable incidents. IDT will also review individual incidents weekly to ensure proper bsp's, staff training, and on-going procedures are in place to ensure safety of all consumers when consumer to consumer abuse is reported.	11/07/2013	

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	<p>policies and procedures to ensure all allegations of abuse/neglect/exploitation and injuries of unknown sources were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law and were thoroughly investigated. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse, neglect, mistreatment and injuries of unknown sources were reported immediately to the administrator and to BDDS and APS for client D's alleged verbal abuse. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse/neglect/mistreatment/exploitation and injuries of unknown sources were thoroughly investigated regarding client D's alleged verbal abuse. Please see W154.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13.</p>						

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			

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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 4 of 4 sample clients (A, B, C and D), and 3 additional clients (E, F and G) the facility neglected to develop and implement written policies and procedures to ensure all allegations of abuse/neglect/exploitation and injuries of unknown sources were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law and were thoroughly investigated.</p> <p>Findings include:</p> <p>On 09/26/13 at 11:50 AM the facility's BDDS Reports, investigations and incident/accident reports were reviewed from 08/01/13 through 10/01/13 and indicated the following:</p> <p>1. 09/24/13: An incident report for client D indicated, "[Client D] has consistently throughout the entire 2 (PM) - 8 p (PM) has been verbally mean to his fellow housemates. There are three inpatient (sic) that he picks on the most. Repeated</p>	W000149	In regard to W149, failing to ensure that the facility had written policy and procedures to ensure the facility immediately reported all allegations of abuse, neglect, mistreatment, exploitation and injury of unknown origin, and that the policy stated that investigations must be completed within 5 working days of the incident, the agency policy has been corrected to contain the needed procedures and updated policy. All policies and procedures that are changed will be reviewed by the Leadership team to ensure they contain proper language and procedures are accurate. New policies/procedures will not be implemented without Leadership team approval. This will ensure that changes are not made to procedures and put in place without proper review to eliminate missing or misinformation. In regard to alleged verbal abuse from one client to another, without investigation, ASI has implemented a behavior plan to address verbal escalation from this consumer. S	11/07/2013	

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	<p>redirected [client D], telling him he could not speak to others this way - he agreed but would very soon repeat his actions." The form did not indicate the Administrator was notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>2. 09/29/13: An incident report for client D indicated, "It was reported to me this morning that after I left last evening [client D] told 3rd shift staff that he was going to refuse the van and dining seating plan b/c (because) he refuses to sit anyways (sic) near someone who is a 'slobber box' and sucks his thumb like a four year old. These arrangements & changes have become necessary b/c [client D's] constant picking on 2 sometimes 3 of his housemates. Reported to PC (Programming Coordinator) & completed documentation as instructed." The form did not indicate the Administrator was notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>3. 09/29/13: An incident report for client D indicated, "As I was training a new hire - [client D] was sitting within hearing range when I mentioned that the menu had to be followed& there could not be</p>						

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	<p>anymore late night snacking. [Client D] became agitated and went outside where another consumer was sitting in the swing. [Client D] went outside & asked said consumer if he had told on him for snacking (sic) when consumer said no [client D's] reply to this was 'you better hope you didn't.'" The form did not indicate the Administrator was notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>4. 09/30/13: An incident report for client D indicated, "[Client D] was in living room watching TV. One of housemates was talking and he told her to shut up that he was watching TV. Staff verbally redirected [client D] (sic) explain (sic) that he could not speak to his housemates like that." The form did not indicate the Administrator was notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated all allegations of abuse are to be reported immediately to the Administrator, a report sent to BDDS and an investigation conducted immediately. She indicated staff had failed to immediately report</p>						

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	<p>these incidents.</p> <p>A review of the revised facility policy Abuse, Neglect and Exploitation dated September 2013, was conducted on 09/30/13 at 11:15 AM. The policy indicated, "Verbal abuse: Any yelling, cursing, screaming, threatening, etc., language directed toward any consumer...Emotional Abuse: Any action toward a consumer with the intent or possible intent of causing the consumer emotional anguish...Humiliation: Any attempt to embarrass, shame, disgrace, or dishonor the 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 (sic) case of abuse, neglect, or exploitation to the Adult Protective Services to the Child</p>						

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	<p>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 "Written September 2013" on 09/30/13 at 11:15 AM indicated: "Purpose: To ensure that all allegations of abuse, neglect, and exploitation against consumers are taken seriously and addressed to protect consumers...It is the policy of Abilities Services that all staff is (sic) trained to identify, report, and documents incidents of alleged abuse, neglect, or exploitation committed by any person against a consumer. All staff is considered mandatory reporters of such allegations. All staff is (sic) trained to identify examples of abuse, neglect, and exploitation and report them to their immediate supervisor and/or an Agency Director immediately...."</p> <p>The facility Policy failed to indicate abuse, neglect, exploitation and injuries of unknown sources are to be reported immediately to the administrator. The policy failed indicate the results of all investigations must be reported to the administrator or designated representative in accordance with State law within five working days of the discovery of the</p>				

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	<p>abuse/neglect/injury of unknown origin.</p> <p>On 10/04/13 at 12:10 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 abuse should be immediately reported to the administrator and an investigation immediately started. The PD indicated they were updating their policy and procedures.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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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 4 of 20 internal incident reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report allegations of abuse immediately to the Administrator, in regard to client D's behavior.</p> <p>Findings include:</p> <p>On 09/26/13 at 11:50 AM the facility's BDDS Reports, investigations and incident/accident reports were reviewed from 08/01/13 through 10/01/13 and indicated the following:</p> <p>1. 09/24/13: An incident report for client D indicated, "[Client D] has consistently throughout the entire 2 - 8 p has been verbally mean to his fellow housemates. There are three inparticular (sic) that he picks on the most. Repeated redirected [client D], telling him he could not speak to others this way - he agreed but would very soon repeat his actions." The form did not indicate the Administrator was</p>	W000153	<p>In response to W153, ASI failed to report and investigate alleged verbal abuse from one consumer to another. The statements were addressed with the consumer, and staff failed to identify these statements as verbal abuse. Staff have been re-trained that this is a reportable incident and requires an investigation per policy. All IR's are being reported to QIDP, PC, Nurse and PD. This will ensure no IR's are missed. QIDP, Nurse or PC will investigate consumer to consumer abuse following ASI procedures for investigation. PD will be notified that the investigation has started and will be contacted for review within 5 working days of the incident. All investigations will be reviewed by Administrative Director during this time period also. A review on incidents in safety committee bi-monthly meeting will provide oversight of reportable incidents. IDT will also review individual incidents weekly to ensure proper bsp's, staff training, and on-going procedures are in place to ensure safety of all consumers when consumer to consumer abuse is reported.</p>	11/07/2013	

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	<p>notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>2. 09/29/13: An incident report for client D indicated, "It was reported to me this morning that after I left last evening [client D] told 3rd shift staff that he was going to refuse the van and dining seating plan b/c (because) he refuses to sit anyways (sic) near someone who is a 'slobber box' and sucks his thumb like a four year old. These arrangements & changes have become necessary b/c [client D's] constant picking on 2 sometimes 3 of his housemates. Reported to PC (Programming Coordinator) & completed documentation as instructed." The form did not indicate the Administrator was notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>3. 09/29/13: An incident report for client D indicated, "As I was training a new hire - [client D] was sitting within hearing range when I mentioned that the menu had to be followed& there could not be anymore late night snacking. [Client D] became agitated and went outside where another consumer was sitting in the swing. [Client D] went outside & asked</p>						

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	<p>said consumer if he had told on him for snacking (sic) when consumer said no [client D's] reply to this was 'you better hope you didn't.'" The form did not indicate the Administrator was notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>4. 09/30/13: An incident report for client D indicated, "[Client D] was in living room watching TV. One of housemates was talking and he told her to shut up that he was watching TV. Staff verbally redirected [client D] (sic) explain (sic) that he could not speak to his housemates like that." The form did not indicate the Administrator was notified of the client abuse or an investigation to the incident. There was no BDDS report to indicate the client abuse was reported.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated all allegations of abuse are to be reported immediately to the Administrator, a report sent to BDDS and an investigation conducted immediately. She indicated staff had failed to immediately report these incidents.</p> <p>This federal tag relates to complaint #IN00132710.</p>						

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	<p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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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 record review and interview for 4 of 20 internal incident reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to investigate the alleged verbal abuse by client D.</p> <p>Findings include:</p> <p>On 09/26/13 at 11:50 AM the facility's BDDS Reports, investigations and incident/accident reports were reviewed from 08/01/13 through 10/01/13 and indicated the following:</p> <p>1. 09/24/13: An incident report for client D indicated, "[Client D] has consistently throughout the entire 2 (PM) - 8 p (PM) has been verbally mean to his fellow housemates. There are three inparticular (sic) that he picks on the most. Repeated redirected [client D], telling him he could not speak to others this way - he agreed but would very soon repeat his actions." There was no investigation of the alleged verbal abuse.</p> <p>2. 09/29/13: An incident report for client D indicated, "It was reported to me this</p>	W000154	In response to W154, ASI failed to report and investigate alleged verbal abuse from one consumer to another. The statements were addressed with the consumer, and staff failed to identify these statements as verbal abuse. Staff have been re-trained that this is a reportable incident and requires an investigation per policy. All IR's are being reported to QIDP, PC, Nurse and PD. This will ensure no IR's are missed. QIDP, Nurse or PC will investigate consumer to consumer abuse following ASI procedures for investigation. PD will be notified that the investigation has started and will be contacted for review within 5 working days of the incident. All investigations will be reviewed by Administrative Director during this time period also. A review on incidents in safety committee bi-monthly meeting will provide oversight of reportable incidents. IDT will also review individual incidents weekly to ensure proper bsp's, staff training, and on-going procedures are in place to ensure safety of all consumers when consumer to consumer abuse is reported	11/07/2013	

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	<p>morning that after I left last evening [client D] told 3rd shift staff that he was going to refuse the van and dining seating plan b/c (because) he refuses to sit anyways (sic) near someone who is a 'slobber box' and sucks his thumb like a four year old. These arrangements & changes have become necessary b/c [client D's] constant picking on 2 sometimes 3 of his housemates. Reported to PC (Programming Coordinator) & completed documentation as instructed." There was no investigation of the alleged verbal abuse.</p> <p>3. 09/29/13: An incident report for client D indicated, "As I was training a new hire - [client D] was sitting within hearing range when I mentioned that the menu had to be followed& there could not be anymore late night snacking. [Client D] became agitated and went outside where another consumer was sitting in the swing. [Client D] went outside & asked said consumer if he had told on him for snacking (sic) when consumer said no [client D's] reply to this was 'you better hope you didn't.'" There was no investigation of the alleged verbal abuse.</p> <p>4. 09/30/13: An incident report for client D indicated, "[Client D] was in living room watching TV. One of housemates was talking and he told her to shut up that</p>			

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	<p>he was watching TV. Staff verbally redirected [client D] (sic) explain (sic) that he could not speak to his housemates like that." There was no investigation of the alleged verbal abuse.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated all allegations of abuse are to be reported immediately to the Administrator and an investigation conducted immediately.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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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 1 of 4 sampled clients (client B) to specifically indicate how staff were to monitor his ambulation and use of his wheelchair and walker.</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 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</p>	W000240	In regard to W240, ASI failed to have fall risk plans in place. The fall risk plan is now in place. ASI's nurse is reviewing all COC's and completing all assessments needed according to schedule. Quality Assurance monthly meetings will review schedule for consumers assessments to ensure they are being completed. RN oversight will take place monthly to report any issues noted in random review of medical files. The RN will provide a written report to the PD and Executive Director of her findings.	11/07/2013	

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	<p>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 B's record contained incident reports dated 09/20/13, 09/22/13 and 09/23/13 which indicated client B had fallen.</p> <p>On 10/04/13 at 12:10 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated all the risk plans had not yet been completed and were not in the files. She indicated client B was at risk for falls, and a fall risk plan had not been completed. She indicated client B did not yet have instructions regarding a plan for his ambulation using his walker or the use of the wheelchair.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>						

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W000312	<p>483.450(e)(2) DRUG USAGE</p> <p>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 3 of 3 sampled clients (clients A, 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 A's records were reviewed on 09/27/13 at 12:15 PM. Client A's BSP (Behavior Support Plan) dated 01/06/13 indicated client A's diagnosis included Major Depressive Disorder and Attention-Deficit/Hyperactivity Disorder (ADHD). The plan indicated his behaviors included difficulty telling the truth and difficulty getting out of bed/staying awake. The BSP indicated client A was on Prozac (depression), Wellbutrin (depression), Ability (antipsychotic) and Daytrana (ADHD). The BSP indicated, "...Should [client A] demonstrate marked improvement in his</p>	W000312	<p>In regard to W312, titration plans for medication related to behaviors, ASI failed to include baseline numbers to use for monitoring the reduction in behaviors. The IDT met and reviewed all data with the behavior specialist. The behavior specialist revised the plans and included the baseline numbers. To identify any behavior plan needs, all IR's are being sent to the behavior specialist and a monthly summary of behavior tracking. PC's are doing tracking sheet reviews weekly to ensure data is recorded. This will allow any issues to be identified. IR's and behavior tracking is monitored by HRC that meets bi-monthly. PD and Administrative Director oversees this committee. BSP's have been updated to include titration plans. In response to letter dated November 14, 2013, ASI's IDT has met and developed reasonable criteria to for the client to meet in order to have an opportunity for meds to be reduced if so indicated. BSP's were updated to include criteria. This was completed by 11/7/2013. Prior to this, there</p>	11/07/2013

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	<p>mood, anxiety/agitation, and/or hyperactivity/impulse control 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 that targets this behavior...." The BSP did not include a titration plan for the medication.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated they were in the process of working with the behavior specialist to update all of the behavior plans and client B's BSP had not been updated yet. She indicated the BSP should contain a titration plan.</p> <p>2. Client B's records were reviewed on 09/27/13 at 1:37 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>		was not a titration plan.		

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	<p>that targets this behavior...." The BSP did not include a titration plan for the medication.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated they were in the process of working with the behavior specialist to update all of the behavior plans and client B's BSP had not been updated yet. She indicated the BSP should contain a titration plan.</p> <p>3. Client C's records were reviewed on 09/27/13 at 2:15 PM. Client C's BSP dated 09/17/13 indicated client C's behaviors included anxiety/agitation. The BSP indicated client C was on Klonopin for the anxiety/agitation. The BSP indicated, "...This data is to provide information to [client C's] doctor for him to consider a medication reduction plan...Should [client C] demonstrate marked improvement as evidenced by having a 50% reduction from baseline over 6 months in her emotional outbursts that may lead to physical aggression...the team may consider making an appointment with her doctor to consider the possibility of a reduction in the dosage of the medication that targets this behavior (Klonopin). The BSP did not indicate what the "baseline" was for client C.</p>				

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	<p>On 10/04/13 at 12:10 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client C's BSP did not indicate what the baseline was and the plan did not contain any measurable component for a medication reduction.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p>						

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients A and B), and 1 additional client (client F), by not ensuring clients received nursing services according to their medical needs: by failing to ensure medications were administered at the most effective time for a specific medication for clients A and F; by failing to have a fall risk plan and an ambulation plan for client B; and to include instructions and documentation for client A's medication patch removal.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 09/27/13 from 6:50 AM until 8:00 AM and staff #3 and #4 were on duty. At 6:56 AM client A was called to the medication administration area and was given his medications which included Prilosec (gastroesophageal reflux disease) 40 mg (milligram) and he placed a Daytrana (hyperactivity) patch on his right hip area. Client A walked directly to the dining room table and started eating breakfast. At 7:07 AM client F came to the medication area and took his medications which included Prilosec 20</p>	W000331	In regard to W331, ASI failed to have a fall risk plan, instructions for medication patch removal and failure to ensure medications were administered at the most effective times, these issues have been fixed. All COC's are being immediately scanned to the agency nurse to ensure correct measures are in place for all prescriptions. A monthly pharmacy review upon delivery to check MAR is being completed by two staff to ensure orders are correct. Quality Assurance will review monthly any follow up needed for pharmacy related issues. Nurse will provide follow up. The fall risk plan is now in place. ASI's nurse is reviewing all COC's and completing all assessments needed according to schedule. Quality Assurance monthly meetings will review schedule for consumers assessments to ensure they are being completed. RN oversight will take place monthly to report any issues noted in random review of medical files. The RN will provide a written report to the PD and Executive Director of her findings. In response to letter dated November 14, 2013, ASI's nurse will conduct a med pass review once a week at each group home. She will ensure that it is a different staff that she	11/07/2013			

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	<p>mg and Levothyroxine (thyroid) 150 mcg (microgram). Interview with staff #2 at 7:10 AM was conducted and she indicated client F had already eaten about 20 minutes prior to the medications.</p> <p>Client A's September 2013 MAR (Medication Administration Record) was reviewed on 09/27/13 at 7:12 AM. The MAR indicated client A had the following medication order: Prilosec 40 mg - take one daily and Daytrana (patch) 20 mg/9hr (hour) - apply 1 patch topically daily - remove old patch first.</p> <p>Client F's September 2013 MAR was reviewed on 09/27/13 at 7:13 AM. The MAR indicated client C had the following medication orders: Prilosec 20 mg - take one daily and Levothyroxine 150 mcg take one daily.</p> <p>On 09/27/13 at 9:30 AM a review of the 2010 Nursing Spectrum Drug Handbook indicated nursing considerations for these medications included taking the medication 30 to 60 minutes before a meal (on an empty stomach). Client A took the medication, walked directed to the table and started eating breakfast. Client F had eaten prior to taking the medications.</p> <p>On 09/27/13 at 9:45 AM a review of the</p>		<p>reviews each week during the med pass. RN oversight will include a check of all med charts monthly for the first 6 months. If this corrects the issues, it will be changed to a random sampling of files each month thereafter.</p>		

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	<p>pharmacy insert for the Daytrana was reviewed. The information indicated the patch was to be removed 9 hours after it was applied and to not wear the patch any longer than 9 hours in a 24 hour period.</p> <p>The LPN (Licensed Practical Nurse) was interviewed on 10/04/13 at 12:10 PM. The LPN indicated there were nursing considerations for certain medications and they should be followed. She indicated the Prilosec and the Levothyroxine should have been given on an empty stomach at least 30 minutes before the meal. She also indicated the Daytrana patch should be removed after 9 hours. She indicated there was not a tracking or documentation system to ensure the patch was removed within that time. She stated, "it probably" should be recorded on the MAR of the removal.</p> <p>2. Client B's records were reviewed on 09/27/13 at 1:35 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</p>				

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	<p>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 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>Client B's record contained incident reports dated 09/20/13, 09/22/13 and 09/23/13 which indicated client B had fallen.</p> <p>On 10/04/13 at 12:05 PM an interview with the Program Director (PD) was conducted. The PD indicated it was the responsibility of the nurse to complete fall risk plans.</p> <p>On 10/04/13 at 12:10 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated all the risk plans had not yet been completed and were not in the files. She indicated client B was at risk for falls, and a fall</p>			

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	<p>risk plan had not been completed. She indicated client B did not yet have instructions regarding a plan for his ambulation using his walker.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				

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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 3 of 4 sampled clients (clients A, C and D) and 1 additional client (client G) at meal time.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 09/26/13 from 3:35 PM until 5:30 PM and staff #1 and #2 were on duty. The supper menu included baked fish, french fries, vegetables, bread and butter. The table settings included plates, napkins, a glass and a spoon. There were no knives or forks at any of the table settings. At 4:46 PM client G was observed to push her fish around her plate trying to cut it to take a bite. At 4:50 PM client G repeated, "cut please" "cut please." Staff #1 asked her if she wanted her fish cut, got a knife and cut the fish into bites. Clients A, C, D, and G pushed their food around the plate trying to place it on the spoon. 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</p>	W000484	In response to W484, the facility failed to provide a full set of silverware for clients at meal time, ASI has implemented weekly site visitations (announced and unannounced) to observe many different times that staff work with consumers in the home. These visitations are done by PC, QIDP, Nurse, Assistant Coordinator and Med Admin Assistant. Site Visitation forms are completed on each visit and sent directly to the PD and Administrative Director for review. Any issues needing immediate attention require a phone call to a Director. All site visitations are reviewed in Quality Assurance monthly. All staff have been re-trained on meal time procedures. Review of training topics take place monthly at staff meetings to ensure all staff are reminded of procedures. In response to letter dated November 14, 2013, weekly site visits include a minimum of 3 visits a week to each group home site.	11/07/2013	

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 10/08/2013
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	<p>and they would be able to cut the fish and fries 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 09/27/13 at 12:15 PM. Client A's Comprehensive Functional Assessment (CFA) dated 07/16/13 indicated client A was was able to use a fork and spoon independently.</p> <p>Client C's records were reviewed on 09/27/13 at 2:15 PM. Client C's CFA dated 02/15/13 indicated client C was able to use a fork and spoon independently.</p> <p>Client D's records were reviewed on 09/27/13 at 3:55 PM. Client D's CFA dated 03/25/13 indicated client D was able with to use a fork, knife and spoon independently.</p> <p>Client G's records were reviewed on 09/27/13 at 4:45 PM. Client G's CFA dated 11/09/12 indicated client G was able with to use a fork, knife and spoon independently.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated the clients should have a full set of silverware.</p>			

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	<p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>			

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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 4 of 4 sampled clients (clients A, B, C and D) and 1 additional clients (client G), 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 09/26/13 from 3:35 PM until 5:30 PM and staff #1 and #2 were on duty. The supper menu included baked fish, french fries, vegetables, bread and butter. The table settings included plates, napkins, a glass and a spoon. There were no knives or forks at any of the table settings. At 4:04 PM client D fixed a flavored drink mix in a pitcher, poured it into glasses and client A took the glasses to the table and set one at each place. At 4:46 PM client G was observed to push her fish around her plate trying to cut it to take a bite. At 4:50 PM client G repeated, "cut please" "cut please." Staff #1 asked her if she wanted her fish cut, got a knife and cut the fish into bites. Clients A, C, D, and G pushed their food around the plate trying to place it on the spoon. An</p>	W000488	In response to W484, the facility failed to provide a full set of silverware for clients at meal time, ASI has implemented weekly site visitations (announced and unannounced) to observe many different times that staff work with consumers in the home. These visitations are done by PC, QIDP, Nurse, Assistant Coordinator and Med Admin Assistant. Site Visitation forms are completed on each visit and sent directly to the PD and Administrative Director for review. Any issues needing immediate attention require a phone call to a Director. All site visitations are reviewed in Quality Assurance monthly. All staff have been re-trained on meal time procedures. Review of training topics take place monthly at staff meetings to ensure all staff are reminded of procedures. In response to letter dated November 14, 2013, weekly site visits include a minimum of 3 visits a week to each group home site.	11/07/2013	

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	<p>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 the fish and fries 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 09/27/13 at 12:15 PM. Client A's Comprehensive Functional Assessment (CFA) dated 07/16/13 indicated client A was able with assistance to cut up food.</p> <p>Client B's records were reviewed on 09/27/13 at 1:37 PM. Client B's CFA dated 04/19/13 indicated client B was able with assistance to pour beverages.</p> <p>Client C's records were reviewed on 09/27/13 at 2:15 PM. Client C's CFA dated 02/15/13 indicated client C was able with assistance to cut up food and pour beverages.</p> <p>Client D's records were reviewed on 09/27/13 at 3:55 PM. Client D's CFA dated 03/25/13 indicated client D was able with assistance to cut up food.</p> <p>Client G's records were reviewed on 09/27/13 at 4:45 PM. Client G's CFA dated 11/09/12 indicated client G was</p>			

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	<p>able with assistance to cut up food and pour beverages.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated the clients could have cut their own fish and fries with assistance and staff should not have done that for them. She also indicated staff should have assisted with clients to pour their own drinks.</p> <p>This federal tag relates to complaint #IN00132710.</p> <p>This deficiency was cited on 08/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>				