

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for the investigation of complaint #IN00145252.</p> <p>COMPLAINT #IN00145252: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: April 29, 30 and May 1 and 2, 2014.</p> <p>Facility number: 005592 Provider number: 15G736 AIM number: 200859130</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/16/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p>			

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Based on record review and interview, the governing body failed for 2 of 3 sampled clients and 2 additional clients (clients A, B, D and F), to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Please refer to W149: The governing body failed for 2 of 3 sampled clients and 2 additional clients (clients A, B, D and F), to ensure implementation of written policy and procedures to prevent client to client aggression, to investigate injuries of unknown origin, immediately reporting allegations of staff verbal abuse and following client B's "Line of sight protocol" to prevent elopement.</li> <li>2. Please refer to W153: The governing body failed for 1 additional client (client F), to ensure staff reported allegations of staff abuse/neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</li> <li>3. Please refer to W154: The governing body failed for 3 of 3 incidents of unknown injuries, involving 1 additional client (client D), to provide written evidence thorough investigations were</li> </ol>	W000104	In regard to W104, the governing body must exercise general policy, budget, and operating direction over the facility, ASI failed to provide oversight to ensure the abuse and neglect policy was implemented. To correct this deficiency, any time an Incident Report is written, the DSP must notify the Programming Coordinator, QIDP, Programming Director, Director of Administration, 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 process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. All completed investigations of consumer to consumer abuse will be reviewed in the weekly HRC or Supervision meeting. The investigation will be reviewed for thoroughness and need for follow up. Documentation of review will be in the meeting notes. Additionally all medication errors are being reviewed weekly to ensure proper retraining is taking place to eliminate repeated med errors. Staff will be retrained	05/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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
	conducted.  4. Please refer to W157: The governing body failed for 2 of 3 sampled clients and 1 additional client (clients A, B and F), to take sufficient/effective corrective measures in regard to preventing medication errors.  9-3-1(a)				monthly on the requirement to immediately report any allegation of abuse, neglect and exploitation For new hires, the agency recruiter, or designee will follow up weekly with the staff for the first month to review policies of reporting and answer any questions Review of reporting procedures will occur each month at staff meetings Failure to follow policies and procedures has written disciplinary procedures		
W000149	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. Based on record review and interview for 2 of 3 sampled clients and 2 additional clients (clients A, B, D and F), the facility failed to implement written policy and procedures to prevent client to client aggression, to investigate injuries of unknown origin, immediately reporting allegations of staff verbal abuse and following client B's "Line of sight protocol" to prevent elopement.			W000149	In regard to W149,ASI failed to implement written policy and procedures to prevent client to client aggression, to investigate injuries of unknown origin, immediately report allegations of staff verbal abuse and follow written protocol for line of sight. Oversight to ensure the abuse and neglect policy was implemented to correct this deficiency includes that any time an Incident Report is written, the		05/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigation records was conducted on 4/29/14 at 11:29 A.M.. Review of the records dated 2/1/14 to 4/29/14 indicated:</p> <p>1. Investigation records of client to client aggression involving clients A and D indicated the following:</p> <p>-Investigation dated 3/10/14 involving clients A and D indicated: "[Client D] pinched [client A] on the back and the housemate [client A] scratched at [client D]'s arm because he didn't want him to sit on the couch next to him."</p> <p>-Investigation dated 3/17/14 involving clients A and D indicated: "Staff reported that when she walked into the kitchen housemate [client D] had his hand in a fist raised to hit [client A]. Staff redirected [client D] away from [client A]. [Client A] stated that housemate had already hit him. No staff actually saw [client D] hit [client A]. [Client A] stated [client D] hit him on the back....Housemates [client D] and [client A] will be kept separated as much as possible."</p>		<p>DSP must notify the Programming Coordinator, QIDP, Programming Director, Director of Administration, 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 process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. All completed investigations of consumer to consumer abuse will be reviewed in the weekly HRC or Supervision meeting. The investigation will be reviewed for thoroughness and need for follow up. Documentation of review will be in the meeting notes. Additionally all medication errors are being reviewed weekly to ensure proper retraining is taking place to eliminate repeated med errors. Staff will be retrained monthly on the requirement to immediately report any allegation of abuse, neglect and exploitation For new hires, the agency recruiter, or designee will follow up weekly with the staff for the first month to review policies of reporting and answer any questions Review of reporting</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>-Investigation record dated 4/11/14 involving clients A and D indicated: "Another consumer (client A) was walking past [client D] in the kitchen. [Client D] reached out and grabbed the other consumer's walker. [Client D] was directed to let go of the walker, he refused at first, staff continued to direct him to let go. As he let go he scratched the arm of the other consumer. Staff advised [client D] it was not appropriate to grab other consumer's items. Staff should always be aware when [client D] is around other consumer to assure no further incidents. All staff will be re-trained on this at staff meeting."</p> <p>-BDDS report dated 4/14/14 involving clients A and D indicated: "[Client A]'s roommate (client D) was in their room getting ready for bed. [Client A] walked into the room and towards his roommate. His roommate reached out and grabbed [client A] and scratched his arm and started yelling at [client A]. [Client A] walked out of the room and told staff, he then said he wasn't going back in the room until his roommate was in bed. [Client A] then sat down on the couch in the living room. The next thing staff new (sic) [client A] was back in their room. [Client A] had slapped his roommate in the face. Staff redirected [client A] out of the room and told him that was not the</p>		<p>procedures will occur each month at staff meetings Failure to follow policies and procedures has written disciplinary procedures.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>appropriate way to handle situations. Staff kept [client A] and his roommate separated for the remainder of the night until they were both sleeping....His roommate (client D) has a watchful eye protocol that states: '[Client D] should not be within arms length of other consumers, not right next to them to ensure safety...Staff should always be aware of [client D]'s behaviors while around other consumers...If [client D] is having a behavior staff should put themselves between [client D] and other consumers...[Client D] and [client A] should be encouraged to sit separate from each other at the dinner table...Staff should be in [client D]'s bedroom with him when he and his roommate are in there and are not sleeping...Staff should check [client D]'s room every 30 minutes throughout the night to assure he is still sleeping...Staff will go over [client D]'s proper social interaction social story daily."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. The QIDP indicated client D has a watchful eye protocol in which staff are to make sure he is not within arms reach of other clients. The QIDP indicated the facility is considering moving clients A and D to different bedrooms since they</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>are currently roommates.</p> <p>2. Incidents of injury of unknown origin involving client D indicated the following:</p> <p>-Investigation dated 3/25/14 involving client D indicated: "QDDP (Qualified Developmental Disabilities Professional) received a message that [client D] has three bruises on his arm. One on his upper right arm and 2 on his right forearm. The staff was not sure where these bruises came from.... We were not able to determine where the bruises came from, since [client D] is on medications that cause him to bruise easily it could have been from when he was being transported or moved. [Client D] was not able to tell us where they came from but did say they did not come from staff. all (sic) staff are to make sure they are transporting and moving [client D] carefully. They are to be documenting any bruises they see."</p> <p>-Investigation dated 3/26/14 involving client D indicated: "While (sic) getting [client D] dressed this morning staff noticed three bruise on his right knee (brownish-Purple), a bruise on his right elbow and his left hand all brownish purple. Staff asked [client D] where he got them and he replied he didn't</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>know....After investigating it was determined that he got the bruises when he wheels himself around the house and up to the dinner table."</p> <p>-BDDS report dated 4/26/14 involving client D indicated: "[Client D] was found on the floor at his bedside by staff at 6:00 A.M.. Last check on consumer stated by staff was at 5:30 A.M. when he was repositioned in bed on his side facing the wall. He has a small scratch and bruise on his right knee."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. The QIDP indicated staff should follow the facility's abuse/neglect policy. When asked if the facility's policy was implemented in regards to the mentioned BDDS reports and investigations, the QIDP indicated they were not. The QIDP indicated the staff and clients involved were interviewed in regard to the mentioned incidents. When asked if all clients and all staff who worked at the group home were interviewed, she indicated she did not know. When asked if an investigation was conducted in regards to the 4/26/14 incident involving client D, the QIDP indicated she was not sure.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(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>3. Investigation record involving client B's elopement and staff neglecting to implement his line of sight protocol indicated the following:</p> <p>-Investigation dated 4/21/14 involving client B indicated: "During transport time at day program [client B] was able to make it out the back door and around to the front of the office. 4 staff were working at the time of the elopement. [Client B] is on a line of sight protocol which all staff are trained on. Staff were able to direct [client B] into the van for transport home."</p> <p>A review of client B's record was conducted on 4/30/14 at 2:40 P.M.. Review of his Behavior Support Plan dated 9/17/13 indicated: "9/15/12...Changes made: Updated plan and addition of Watchful Eye Protocol with increased restrictions due to recent incidents of elopement... Watchful Eye Protocol: Due to an increase in recent, successful elopement behaviors, [Facility name] has placed [client B] on a more restrictive Watchful Eye Protocol. [Client B] should be in staff's LINE OF SIGHT AT ALL TIMES. The only exception to this is when [client B] is in the bathroom or bedroom; staff should ensure that he is in one of these locations initially and then do 2-3 minute checks to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(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>ensure he has remained in that location. Staff should be in the common area to ensure that he has not slipped out of the bathroom or bedroom and out the main doors of the home or habilitation program. This protocol remains in place during sleeping hours as well. In addition, when [client B] is in the backyard, staff should be outside with him to ensure that he has not left the area through the fence."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. The QIDP indicated staff did not follow client B's line of sight protocol.</p> <p>4. Investigation record of allegations of staff abuse/neglect indicated the following:</p> <p>-Investigation record dated 4/1/14 involving clients D and F and Staff #25 indicated; "[Staff #26] worked the A.M. shift 6:00 A.M. to 10:00 A.M., with [Staff #25] on the morning of the 1st. The incident occurred around 7:00 A.M. and continued until 8:30 A.M.. During this time [Staff #26] alleged that [Staff #25] was verbally abusive to [client D] and took [client D] to the bathroom and left him on the toilet for 20 minutes. She also alleged that [Staff #25] was rough</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(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>when bathing [client F] approximately 3/25."</p> <p>-BDDS report dated 3/25/14...Date of knowledge: 4/7/14...Submitted date: 4/7/14 involving client F and Staff #25 indicated: "During an investigation of verbal abuse towards a different client it was reported of verbal abuse towards [client F]. It was reported that [Staff #25] would yell at her to stop crying and would handle her rough during showers. Emotional/Verbal abuse was not substantiated. The investigation concluded that [client F] cried in the shower with most staff due to not liking the shower. [staff #25] has a very direct tone, but verbal abuse could not be substantiated....[Staff #25] was talked to about her tone and how to use a better tone with the consumers."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. The QIDP indicated staff should follow the facility's abuse/neglect policy. When asked if the facility's policy was implemented in regards to the mentioned BDDS reports and investigations, the QIDP indicated they were not. The QIDP indicated all incidents of abuse and neglect are to be immediately reported to the administrator and within 24 hours to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>BDDS. The QIDP indicated the investigation into staff #25 being verbally abusive was unsubstantiated but did further indicate staff #25 had a stern and direct voice.</p> <p>A review of the facility's abuse and neglect policy dated 12/12 was conducted on 4/30/14 at 7:30 P.M.. Review of the policy indicated:</p> <p>"Abilities Services, Inc. Abuse, Neglect, and Exploitation" dated 12/12 indicated: "It is the policy of Abilities Services, Inc. to protect and advocate for the protection and safety of all consumers in accordance with all applicable federal, state, and local laws. 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, regulation, and laws. All staff of Abilities Services, Inc, are MANDATORY REPORTERS of observed or suspected abuse, neglect, and exploitation. Definitions: Verbal Abuse: Any yelling, cursing, screaming, threatening, language directed toward any consumer. Physical Abuse: Any hitting, slapping, kicking, biting, throwing at or attempting to do so, toward a consumer emotional anguish....Neglect: Any action that places or potentially places a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(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 in a position/situation that results in injury. It is also defined as the intentional withholding of the basic necessities of life....Abilities Services, Inc, prohibits the abuse, neglect, exploitation, and mistreatment of an individual, and violation of an individual's rights, to include but is not limited to the following: corporal punishment....It is a priority to notify immediately if actual or suspected Abuse, Neglect, or Exploitation occurs...Resident Elopement: a cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown."</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(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, the facility failed for 1 additional client (client F), to ensure staff reported allegations of staff abuse/neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigation records was conducted on 4/29/14 at 11:29 A.M.. Review of the records dated 2/1/14 to 4/29/14 indicated:</p> <p>-BDDS report dated 3/25/14...Date of knowledge: 4/7/14...Submitted date: 4/7/14 involving client F and Staff #25</p>	W000153	<p>In response to W153, ASI failed to ensure that staff immediately report any allegations of ANE. Oversight to ensure the abuse and neglect policy was implemented to correct this deficiency includes that any time an Incident Report is written, the DSP must notify the Programming Coordinator, QIDP, Programming Director, Director of Administration, 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 reporting with this notification system. Staff will be retrained monthly on the requirement to immediately report any allegation of abuse, neglect</p>	05/30/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>indicated: "During an investigation of verbal abuse towards a different client it was reported of verbal abuse towards [client F]. It was reported that [Staff #25] would yell at her to stop crying and would handle her rough during showers. Emotional/Verbal abuse was not substantiated. The investigation concluded that [client F] cried in the shower with most staff due to not liking the shower. [Staff #25] has a very direct tone, but verbal abuse could not be substantiated....[Staff #25] was talked to about her tone and how to use a better tone with the consumers."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. The QIDP indicated this incident was not immediately reported to the administrator or BDDS. The QIDP further indicated the incident should have been immediately reported to the administrator and within 24 hours to BDDS.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>		<p>and exploitation. Since review of the failure to report, it has been noted that it has consistently been new staff that have not immediately reported possible ANE. For new hires, the agency recruiter, or designee will follow up weekly with the staff for the first month to review policies of reporting and answer any questions. Review of reporting procedures will occur each month at staff meetings for all staff. Failure to follow policies and procedures has written disciplinary procedures</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(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>alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 3 incidents of unknown injuries, involving 1 additional client (client D), the facility failed to provide written evidence thorough investigations were conducted.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigation records was conducted on 4/29/14 at 11:29 A.M.. Review of the records dated 2/1/14 to 4/29/14 indicated:</p> <p>-Investigation dated 3/25/14 involving client D indicated: "QDDP (Qualified Developmental Disabilities Professional) received a message that [client D] has three bruises on his arm. One on his upper right arm and 2 on his right forearm. The staff was not sure where these bruises came from....We were not able to determine where the bruises came from, since [client D] is on medications that cause him to bruise easily it could have been from when he was being transported or moved. [Client D] was not able to tell us where they came from but did say they did not come from staff. all (sic) staff are to make sure they are</p>	W000154	<p>In regard to W154, ASI failed to provide written evidence thorough investigations were conducted. To correct this deficiency, any time an Incident Report is written, the DSP must notify the Programming Coordinator, QIDP, Programming Director, Director of Administration, 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 process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. All completed investigations of consumer to consumer abuse and injuries of unknown origin will be reviewed in the weekly HRC or Supervision meeting. The investigation will be reviewed for thoroughness and need for follow up. Documentation of review will be in the meeting notes. All investigations will require to be signed off by a Director to ensure they are completed thoroughly.</p>	05/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(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>transporting and moving [client D] carefully. They are to be documenting any bruises they see." Further review failed to indicate a thorough investigation was conducted in regards to the documented injuries of unknown origin.</p> <p>-Investigation dated 3/26/14 involving client D indicated: "While (sic) getting [client D] dressed this morning staff noticed three bruise on his right knee (brownish-Purple), a bruise on his right elbow and his left hand all brownish purple. Staff asked [client D] where he got them and he replied he didn't know....After investigating it was determined that he got the bruises when he wheels himself around the house and up to the dinner table." Further review failed to indicate a thorough investigation was conducted in regards to the documented injuries of unknown origin.</p> <p>-BDDS report dated 4/26/14 involving client D indicated: "[Client D] was found on the floor at his bedside by staff at 6:00 A.M.. Last check on consumer stated by staff was at 5:30 A.M. when he was repositioned in bed on his side facing the wall. He has a small scratch and bruise on his right knee." Further review of the record failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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			
	An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. When asked if there was documentation to indicate an investigation was conducted in regards to the mentioned incidents of unknown injuries, the QIDP indicated there were not any investigations.  9-3-2(a)						
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 2 of 3 sampled clients and 1 additional client (clients A, B and F), the facility failed to take sufficient/effective corrective measures in regard to preventing medication errors.  Findings include:  A review of the facility's Bureau of	W000157	In regard to W157, ASI failed to take sufficient/effective corrective measures in regard to preventing medication errors. To correct this deficiency, all medication errors are being reviewed weekly in Safety meetings to ensure proper retraining is taking place to eliminate repeated med errors. The agency nurse will be evaluating the group home	05/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>Developmental Disabilities Services (BDDS) reports dated 2/1/14 to 4/29/14 was conducted on 4/29/14 at 11:28 A.M.. Review of the reports indicated:</p> <p>-BDDS report dated 2/18/14 involving client B indicated: "[Client B] was given his 6:30 A.M. med of omeprazole (Gastroesophageal reflux disease) at 8:00 A.M.. Upon questioning staff it was stated by [Staff #13], [Staff #14], [Staff #15], [Staff #16] and [Staff #17] have not been administering it at 6:30 A.M.. They have been giving it at 8:00 A.M. with his other meds. Staff will receive disciplinary action and retrained on medication administration policy."</p> <p>-BDDS report dated 2/26/14 involving client F indicated: "When [Staff #14] went to apply transdermal patch (medicated adhesive patch) to [client F] on the left side behind the ear. (sic) [Staff #14] checked to remove the old patch and noted [client F] had a patch on both sides and applied the new patch behind the left ear. [Nurse] was notified of the incident. [Staff #13] was the last person to apply the previous patch. [Staff #13] will be retrained on transdermal patch application. [Staff #13] will be submitted for disciplinary action."</p> <p>-BDDS report dated 3/26/14 involving</p>		<p>weekly for needed modifications to MARS, storage, instructions and to answer staff questions. A new system for notification to all staff when a consumers medication has changed is being implemented. Upon clock in to their shift, they will receive notification of any changes. During evaluation, it seemed that most medication errors had occurred due to changes in medications. This should help this deficiency. Staff will be retrained monthly in staff meetings on medication administration procedures. Staff failure to follow medication policies and procedures has written disciplinary procedures</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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 B indicated: "Medication nystatin cream (skin infection) was not applied as directed to consumers (sic) feet on 3/26/14, by [Staff #20]. Medication was not available in the group home at the current time. Medication was to be administered at 8:00 P.M.. Staff will notify house manager and nurse when medications are down to a 3 day supply. Medication was made available for next med pass on 3/27/14 at 8:00 A.M.. [Staff #20] was submitted for disciplinary action and educated on importance of letting nurse and house manager know when medications are not available. Education was given verbally by [House Manager]."</p> <p>-BDDS report dated 4/3/14 involving client D indicated: "Staff passed [client D]'s 8:00 P.M. medication on 4/2/14 and then when she went to pass medications again on 4/3/14 a pill was missing from the Depakote (bipolar) 8:00 P.M. package." Further review of the report indicated the medication could not be found and further indicated the facility did not know if the medication was given to client D.</p> <p>-BDDS report dated 4/19/14...Date of Knowledge 4/21/14...Submitted date: 4/22/14 involving client D indicated: "During a random med audit performed</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>by [Program Coordinator], it was noted [client D] missed 3 consecutive doses of Risperdal 2 mg (antipsychotic). 4/19/14 8:00 A.M. dose was missed by [Staff #15], 4/20/14 dose was missed by [Staff #22] who packed meds for his home visit. 4/21/14 dose was missed by [Staff #26]. The MAR was signed by staff but med was not given noted as bubble pack was not signed. Last date noted on bubble pack was 4/18/14, new pack was not pulled to be given but was available in the house. Staff were all verbally reminded to do 3 checks when passing meds as taught in med core. All 3 staff are submitted for disciplinary action."</p> <p>-BDDS report dated 4/26/14...Date of Knowledge 4/27/14...Submitted Date: 4/28/14 involving client A indicated: "[Group Home Manager] did not pass [client A]'s 5:00 P.M. medication Nadolol (hypertension, anxiety). The MAR (Medication Administration Record) was signed for but the pill was not popped or passed. Staff will receive disciplinary action per [Facility name] policy."</p> <p>-BDDS report dated 2/15/14 involving client A indicated: "Missed two doses of clonazepam .25 mg on 2/15/14 and 2/16/14 while on home visit. All meds were sent home with family to be</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>administered. Will educate family on importance of giving all meds as prescribed."</p> <p>-BDDS report dated 3/9/14...date of knowledge 3/12/14...Submitted date 3/12/14 involving client A indicated: "[Client A] went home with his parents on 3/7/14 until 3/9/14. All of his medications were sent home with him. During a medication check done on 3/12/14 by [Facility nurse] is (sic) was discovered that his Klonopin .25 mg was not passed while he was at home. Mom has a habit of not giving him his Klonopin due to her not wanting him on it. His psych Dr. (Psychiatrist) is weaning him off of the Klonopin. It will be restated to mom how important it is for [client A] to receive his medications while he is at home."</p> <p>-BDDS report dated 3/23/14 involving client A indicated: "Missed a dose of Nadalol during home visit. It was found during med check when consumer arrived back at the group home. We are not able to confirm if it was missed on 3/21/14 or 3/22/14 as he was gone for his 5:00 P.M. dose both of those times. Family education will be given on the importance of receiving medication at dose prescribed and as ordered. Meds will continue to be sent with consumer</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(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 proper administration."</p> <p>-BDDS report dated 4/20/14 involving client D indicated: "[Client D] was out with family on 4/20/14, and missed 12:00 P.M. dose of Depakote. Dose was noted to be missed when staff checked meds in. Family will be reminded that all meds need to be given when out with family at appropriate times."</p> <p>Further review of the reports failed to indicate the facility took effective/sufficient corrective action to prevent recurrence.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. The QIDP indicated all staff are trained on medication administration prior to working at the group home. The QIDP also indicated staff are retrained annually and as needed on medication administration and further indicated staff should administer medications as ordered. The QIDP indicated there should always be a 3 day supply of medication at the group home for all clients' medication. The QIDP indicated group home staff are trained to notify the house manager and nurse when medications are running low. The QIDP indicated group home staff who had been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(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>working at the group home trained newer staff that client B's 6:30 A.M. medications should be given at 8:00 A.M. instead of the prescribed time of 6:30 A.M.. The QIDP indicated client A's mother does not give him his meds when he goes home because she does not like him being on medications.</p> <p>9-3-2(a)</p> <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. Based on record review, and interview, the facility failed to assure drugs administered to 2 of 3 sampled clients and 1 additional client (clients A, B and F) were administered in compliance with the physician's orders.</p> <p>Findings include:  -BDDS report dated 2/18/14 involving client B indicated: "[Client B] was given</p>	W000368	In regard to W368, ASI failed to assure drugs administered were administered in compliance with the physician's orders. To correct this deficiency, all medication errors are being reviewed weekly in Safety meetings to ensure proper retraining is taking place to eliminate repeated med errors. The agency nurse will be evaluating the group home weekly for needed modifications	05/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(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>his 6:30 A.M. med of omeprazole (Gastroesophageal reflux disease) at 8:00 A.M.. Upon questioning staff it was stated by [Staff #13], [Staff #14], [Staff #15], [Staff #16] and [Staff #17] have not been administering it at 6:30 A.M.. They have been giving it at 8:00 A.M. with his other meds. Staff will receive disciplinary action and retrained on medication administration policy."</p> <p>-BDDS report dated 2/26/14 involving client F indicated: "When [Staff #14] went to apply transdermal patch (medicated adhesive patch) to [client F] on the left side behind the ear. (sic) [Staff #14] checked to remove the old patch and noted [client F] had a patch on both sides and applied the new patch behind the left ear. [Nurse] was notified of the incident. [Staff #13] was the last person to apply the previous patch. [Staff #13] will be retrained on transdermal patch application. [Staff #13] will be submitted for disciplinary action."</p> <p>-BDDS report dated 3/26/14 involving client B indicated: "Medication nystatin cream (skin infection) was not applied as directed to consumers (sic) feet on 3/26/14, by [Staff #20]. Medication was not available in the group home at the current time. Medication was to be administered at 8:00 P.M.. Staff will</p>		<p>to MARS, storage, instructions and to answer staff questions. A new system for notification to all staff when a consumers medication has changed is being implemented. Upon clock in to their shift, they will receive notification of any changes. During evaluation, it seemed that most medication errors had occurred due to changes in medications. This should help this deficiency. Staff will be retrained monthly in staff meetings on medication administration procedures. Staff failure to follow medication policies and procedures has written disciplinary procedures</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>notify house manager and nurse when medications are down to a 3 day supply. Medication was made available for next med pass on 3/27/14 at 8:00 A.M.. [Staff #20] was submitted for disciplinary action and educated on importance of letting nurse and house manager know when medications are not available. Education was given verbally by [House Manager]."</p> <p>-BDDS report dated 4/3/14 involving client D indicated: "Staff passed [client D]'s 8:00 P.M. medication on 4/2/14 and then when she went to pass medications again on 4/3/14 a pill was missing from the Depakote (bipolar) 8:00 P.M. package." Further review of the report indicated the medication could not be found and further indicated the facility did not know if the medication was given to client D.</p> <p>-BDDS report dated 4/19/14...Date of Knowledge 4/21/14...Submitted date: 4/22/14 involving client D indicated: "During a random med audit performed by [Program Coordinator], it was noted [client D] missed 3 consecutive doses of Risperdal 2 mg (antipsychotic). 4/19/14 8:00 A.M. dose was missed by [Staff #15], 4/20/14 dose was missed by [Staff #22] who packed meds for his home visit. 4/21/14 dose was missed by [Staff</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>#26]. The MAR was signed by staff but med was not given noted as bubble pack was not signed. Last date noted on bubble pack was 4/18/14, new pack was not pulled to be given but was available in the house. Staff were all verbally reminded to do 3 checks when passing meds as taught in med core. All 3 staff are submitted for disciplinary action."</p> <p>-BDDS report dated 4/26/14...Date of Knowledge 4/27/14...Submitted Date: 4/28/14 involving client A indicated: "[Group Home Manager] did not pass [client A]'s 5:00 P.M. medication Nadolol (hypertension, anxiety). The MAR (Medication Administration Record) was signed for but the pill was not popped or passed. Staff will receive disciplinary action per [Facility name] policy."</p> <p>-BDDS report dated 2/15/14 involving client A indicated: "Missed two doses of clonazepam .25 mg on 2/15/14 and 2/16/14 while on home visit. All meds were sent home with family to be administered. Will educate family on importance of giving all meds as prescribed."</p> <p>-BDDS report dated 3/9/14...date of knowledge 3/12/14...Submitted date 3/12/14 involving client A indicated:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(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] went home with his parents on 3/7/14 until 3/9/14. All of his medications were sent home with him. During a medication check done on 3/12/14 by [Facility nurse] is (sic) was discovered that his Klonopin .25 mg was not passed while he was at home. Mom has a habit of not giving him his Klonopin due to her not wanting him on it. His psych Dr. (Psychiatrist) is weaning him off of the Klonopin. It will be restated to mom how important it is for [client A] to receive his medications while he is at home."</p> <p>-BDDS report dated 3/23/14 involving client A indicated: "Missed a dose of Nadalol during home visit. It was found during med check when consumer arrived back at the group home. We are not able to confirm if it was missed on 3/21/14 or 3/22/14 as he was gone for his 5:00 P.M. dose both of those times. Family education will be given on the importance of receiving medication at dose prescribed and as ordered. Meds will continue to be sent with consumer for proper administration."</p> <p>-BDDS report dated 4/20/14 involving client D indicated: "[Client D] was out with family on 4/20/14, and missed 12:00 P.M. dose of Depakote. Dose was noted to be missed when staff checked meds in."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>Family will be reminded that all meds need to be given when out with family at appropriate times."</p> <p>A review of the facility's "Medication Administration System" Dated 12/12 was conducted on 4/29/14 at 2:30 P.M. and indicated:</p> <p>"Purpose: To ensure medications (administration, destruction, errors) are handled in a safe, appropriate manner...To ensure the medical well being of the individuals served are met with the highest level of service possible, Abilities Services, Inc. employees are trained annually and capable of handling a variety of medication situations....The individual administering the medication will initial completion of each dose given on the MAR and the bubble pack after the medication has been administered as trained."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/14 at 11:20 A.M.. The QIDP indicated all staff are trained on medication administration prior to working at the group home. The QIDP also indicated staff are retrained annually and as needed on medication administration and further indicated staff should administer medications as</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
------------------------------------------------------------	---------------------------------------------------------------------------------

(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>ordered. The QIDP indicated there should always be a 3 day supply of medication at the group home for all clients' medication. The QIDP indicated group home staff are trained to notify the house manager and nurse when medications are running low. The QIDP indicated group home staff who had been working at the group home trained newer staff that client B's 6:30 A.M. medications should be given at 8:00 A.M. instead of the prescribed time of 6:30 A.M.. The QIDP indicated client A's mother does not give him his meds when he goes home because she does not like him being on medications.</p> <p>9-3-6(a)</p>			