

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2013	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(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 pre-determined full recertification and state licensure survey and to the investigation of complaint #IN00132706 completed on 08/09/13.</p> <p>Complaint #IN00132706: Not corrected.</p> <p>Dates of Survey: September 30, October 1, 2, 3 and 4, 2013.</p> <p>Facility Number: 001194 Provider Number: 15G628 AIMS Number: 100245710</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/16/13 by Ruth Shackelford, QIDP.</p>	W000000	This is not required.				

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 observation, interview and record review for 3 of 3 sampled clients (A, B and C) and for 4 additional clients (D, 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</p>	W000104	In response to the letter dated Nov 14, 2013, Disciplinary action does not ensure the maintenance issues are addressed, it is just part of the process of ensuring staff know the importance of notifying a supervisor of a maintenance issue and the importance of the PC scheduling the maintenance to be done immediately. Once a week safety/site checks are completed and reviewed by the Director of Programming and verification of scheduled maintenance is done. Then the process is to follow up at the next visit (the next week) to ensure the issues have been fixed. Any emergency issues are immediately scheduled by the Director of Programming.	11/03/2013	

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	<p>administrator and to BDDS (Bureau of Developmental Disabilities Services) and APS (Adult Protective Services) in accordance with state law.</p> <p>__ To ensure all allegations of abuse/neglect/mistreatment/exploitation and injuries of unknown sources were thoroughly investigated and</p> <p>__ To ensure the clients' home was maintained and in good repair.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/03/13 from 4:00 PM until 4:30 PM. During a walk through of the home with staff #3, the following was observed:</p> <p>__ The fluorescent light in the shower bath was burned out, leaving no other light for clients to use in the shower/bathroom.</p> <p>__ The seat of the shower chair was cracked and peeling.</p> <p>__ A strip of metal below the stove was broken and rusted.</p> <p>__ Client A was missing a door knob on her closet door. Client A was interviewed on 10/04/13 at 4:20 PM. Client A indicated it still had not been fixed yet. Staff #3 was interviewed on 10/04/13 at 4:21 PM and indicated she was not sure why client A did not have a door knob on her closet door.</p>						

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	<p>On 10/03/13 at 4:25 PM an interview with staff #3 indicated all repairs were reported to the HM (manager). Staff #3 stated the the shower chair seat and the stove had been in need of repair "for a long time." Staff #3 indicated the TL (Team Leader) was aware of the needed repairs in the group home.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility for 3 of 3 sample clients (A, B and C), and 4 additional clients (D, E, F and G) to ensure the facility developed and implemented 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. 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 G. Please see</p>						

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	<p>W153.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse/neglect/mistreatment/exploitation and injuries of unknown sources were thoroughly investigated for clients A and G. Please see W154.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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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.	W000149	In regard to failing to ensure that injuries of unknown origin were reported, it was found that the injuries noted were not of unknown origin, but the QIDP failed to complete the incident report stating that the origin of the injuries were known. It is the responsibility of the QIDP to complete the IR's stating the outcome or filing the BDDS and investigating. The QIDP will forward the IR's to PD to ensure they have been completed and what is in process. This will ensure that the forms are completed and the proper steps have been done. Oversight of IR's is completed in Quality Assurance Committee monthly. In regard to the investigation completed by QIDP, staff was interviewed over the phone and the QIDP failed to document this. The IR had the documentation of the statement by the staff working. We have now implemented that in addition to the IR, a statement must be signed by the staff when they are interviewed. PD or another Director will review and sign off on all investigations. In regard to ASI's abuse, neglect and exploitation policy, changes have been made to the policy to state the correct information - that	11/03/2013	

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	<p>Based on record review and interview for 3 of 3 sample clients (A, B and C), and 4 additional clients (D, 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 10/02/13 at 11:29 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>injuries of unknown origin are to be reported immediately and an investigation completed within 5 working days. All policies/procedures that are changed, will be reviewed by the Leadership team to ensure they contain proper language and procedures are accurate. Upon approval by leadership team, new policies/procedures will be put in place. This will ensure that changes are not made and put in place without proper review.</p>				

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	<p>1. 09/13/13: An incident report for client G indicated, "Staff was putting on [client G's] deodorant and noticed he had scratches on his belly. Staff wrote out an Incident Report to give to Group Manager and Nurse." The form did not indicate the Administrator was notified of the scratches or an investigation to the origin of the scratches was conducted. There was no BDDS report to indicate the unknown injury was reported.</p> <p>2. 09/30/13: An incident report for client G indicated, "[Client G] was in living room when staff realized he has a scratch on his neck." The form did not indicate the Administrator was notified of the scratch or an investigation to the origin of the scratch was conducted. There was no BDDS report to indicate the unknown injury was reported.</p> <p>3. A 09/14/13 BDDS (Bureau of Developmental Disabilities Services) report indicated on 09/13/13 at 9:52 PM, "Housemate [client D] returned from work and was eating dinner. [Client A] was sitting at the table with him, housemate [client B] was also around the table. [Client A] told [client B] to stop looking at [client D] ([client A's] boyfriend). [Client B] did not stop looking at [client D]. [Client A] got upset</p>			

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	<p>and pushed [client B] back to her room in her wheelchair. [Client A] then punched [client B] in the ear and shoulder and kicked her in the back. [Client A] knocked [client B's] pictures down and broke the frames. Staff went back to room (sic) and got [client A] out of the room...[Client B] decided to file a police report. The police came out and took statements from all housemates and [client B] was taken to the ER (Emergency Room) per [client B's] request. [Client A] and [client B] (sic) away from each other as much as possible. Staff should keep [client A] in line of sight until further notice. Behavior specialist was notified of incident." An investigation was initiated on 09/13/13. The investigation report did not indicate contain any interviews of the staff working in the home at the time of the incident.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated all injuries of unknown sources 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 injuries of unknown sources. She also indicated all staff on duty should be interviewed during the investigation of</p>						

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	<p>any incident.</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. Physical abuse: Any hitting, slapping, kicking, biting, throwing at, etc., or attempting to do so, toward a consumer, toward a consumer emotional anguish (sic). Emotional Abuse: Any action toward a consumer with the intent or possible intent of causing the consumer emotional anguish. Neglect: Any action that places or potentially places a consumer in a position/situation that results in injury. Is also defined as the intentional withholding of the basic necessities of life. Exploitation: Intentionally taking advantage of a consumer of one's own or another's gain without regard to the welfare or well being of the consumer. Humiliation: Any attempt to embarrass, shame, disgrace, or dishonor the 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</p>						

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	<p>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 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</p>			

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	<p>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 to indicate the results of all investigations must be reported to the administrator or designated representative in accordance with State law within five working days of the discovery of the abuse/neglect/injury of unknown origin (clients A, B, C, D, E, F, and G).</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. 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	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.	W000153	In regard to failing to ensure that injuries of unknown origin were reported, it was found that the injuries noted were not of unknown origin, but the QIDP failed to complete the incident report stating that the origin of the injuries were known. It is the responsibility of the QIDP to complete the IR's stating the outcome or filing the BDDS and investigating. The QIDP will forward the IR's to PD to ensure they have been completed and what is in process. This will ensure that the forms are completed and the proper steps have been done. Oversight of IR's is completed in Quality Assurance Committee monthly. In response to the letter dated November 14, 2013, staff are filling out incident reports, the QIDP failed to write on the IR completed by the staff that the injury was not of unknown origin. The staff that reported failed to note that per previously noted - consumer has scratched his skin due to dryness and has lotion to apply. This particular consumer scratches his stomach frequently and tends to leave marks. When injuries are known, it is the	11/03/2013	

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	Based on record review and interview for 2 of 10 internal incident reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report the injuries of unknown source immediately to the Administrator and to BDDS (Bureau of		responsibility of the QIDP or PC or Nurse to state on the IR that the injury is known and the information known or it is their responsibility to report it as an unknown injury and begin an investigation. Staff can write on the IR if they are aware of the injury as a reoccurring one such as the scratches and have been trained to discuss with QIDP, Nurse or PC if they have any questions. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. The IR's are sent to the PD at the same time they are scanned to the others and the PD is notified by text of all IR's. The safety committee is following up weekly on any BDDS reportable injuries.		

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	<p>Developmental Disabilities Services), in regard to unknown scratches on client G.</p> <p>Findings include:</p> <p>The facility's reportable, investigative records and incident/accident records for August 2013 and September 2013 were reviewed on 09/30/13 at 2:30 PM and included the following:</p> <ol style="list-style-type: none"> 09/13/13: An incident report for client G indicated, "Staff was putting on [client G's] deodorant and noticed he had scratches on his belly. Staff wrote out an Incident Report to give to Group Manager and Nurse." The form did not indicate the Administrator was notified of the scratches or an investigation to the origin of the scratches was conducted. There was no BDDS report to indicate the unknown injury was reported. 09/30/13: An incident report for client G indicated, "[Client G] was in living room when staff realized he has a scratch on his neck." The form did not indicate the Administrator was notified of the scratch or an investigation to the origin of the scratch was conducted. There was no BDDS report to indicate the unknown injury was reported. <p>On 10/04/13 at 12:10 PM an interview</p>						

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	<p>with the Program Director (PD) was conducted. The PD indicated all injuries of unknown sources are to be reported immediately to the Administrator and a report sent to BDDS. She indicated staff had failed to immediately report these injuries of unknown sources.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. 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	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W000154	In regard to failing to ensure that injuries of unknown origin were reported, it was found that the injuries noted were not of unknown origin, but the QIDP failed to complete the incident report stating that the origin of the injuries were known. It is the responsibility of the QIDP to complete the IR's stating the outcome or filing the BDDS and investigating. The QIDP will forward the IR's to PD to ensure they have been completed and what is in process. This will ensure that the forms are completed and the proper steps have been done. Oversight of IR's is completed in Quality Assurance Committee monthly. In regard to the investigation completed by QIDP, staff was interviewed over the phone and the QIDP failed to document this. The IR had the documentation of the statement by the staff working. We have now implemented that in addition to the IR, a statement must be signed by the staff when they are interviewed. PD or another Director will review and sign off on all investigations. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins	11/03/2013	

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			<p>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. ASI has up-dated the report format of this document to ensure it is more complete. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff</p>		

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	<p>Based on record review and interview for 1 of 3 BDDS (Bureau of Developmental Disabilities Services) reports and 2 of 10 internal incidents regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to investigate injuries of unknown source in regard to scratches on client G and protect clients (clients B and D) from physical abuse and property destruction to personal items by client A.</p> <p>Findings include:</p> <p>The facility's reportable, investigative records and incident/accident records for August 2013 and September 2013 were reviewed on 09/30/13 at 2:30 PM and included the following:</p> <p>1. 09/13/13: An incident report for client G indicated, "Staff was putting on [client</p>		<p>investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

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	<p>G's] deodorant and noticed he had scratches on his belly. Staff wrote out an Incident Report to give to Group Manager and Nurse." There was no investigation regarding the origin of the scratches.</p> <p>2. 09/30/13: An incident report for client G indicated, "[Client G] was in living room when staff realized he has a scratch on his neck." There was no investigation regarding the origin of the scratch.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated all injuries of unknown sources are to be investigated immediately. She indicated there were no investigations regarding these injuries.</p> <p>3. A 09/14/13 BDDS (Bureau of Developmental Disabilities Services) report indicated on 09/13/13 at 9:52 PM, "Housemate [client D] returned from work and was eating dinner. [Client A] was sitting at the table with him, housemate [client B] was also around the table. [Client A] told [client B] to stop looking at [client D] ([client A's] boyfriend). [Client B] did not stop looking at [client D]. [Client A] got upset and pushed [client B] back to her room in her wheelchair. [Client A] then punched [client B] in the ear and shoulder and kicked her in the back. [Client A]</p>						

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	<p>knocked [client B's] pictures down and broke the frames. Staff went back to room (sic) and got [client A] out of the room...[Client B] decided to file a police report. The police came out and took statements from all housemates and [client B] was taken to the ER (Emergency Room) per [client B's] request. [Client A] and [client B] (sic) away from each other as much as possible. Staff should keep [client A] in line of sight until further notice. Behavior specialist was notified of incident." An investigation was initiated on 09/13/13. The investigation report did not indicate contain any interviews of the staff working in the home at the time of the incident.</p> <p>On 10/04/13 at 12:10 PM an interview with the Program Director (PD) was conducted. The PD indicated the investigation should have contained interviews with the staff on duty at the time of the incident.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.	W000227	In regard to W227, ASI failed to address the client's behavioral needs, the targeted behavior of physical aggression was removed from the clients BSP due to not have any incidents for an extended period of time. The Behavior Specialist was consulted and team discussed leaving all identified behaviors in the plans regardless of time so that in case of any changes in behavior, there would be a plan to address. Upon review of plans, team will leave in place for all consumers, their identified behaviors. In regard to client with refusals, the behavior specialist was consulted and updated the BSP. 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 oversee this committee. Both BSP's have been updated and staff will be trained by corrected date. In response to the letter	11/03/2013	

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	<p>Based on record review and interview for 2 of 3 sampled clients (clients A and C), the clients' BSPs (Behavior Support Plans) failed to address the clients' identified behavioral needs.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records for August 2013 and September 2013 were reviewed on 09/30/13 at 2:30 PM.</p> <p>A 09/14/13 BDDS (Bureau of Developmental Disabilities Services) report indicated on 09/13/13 at 9:52 PM,</p>		<p>date November 14, 2013, ASI discusses all behaviors in weekly IDT meetings. If targeted behaviors reappear that have been addressed in the past, but taken out of a plan due to not having those behaviors, the IDT will discuss appropriate ways to address the behaviors including revisions to BSPs. If behaviors have not been exhibited for extended periods of time, IDT will address removing the targeted behavior from the plan by revision to the ISP. Only identified behaviors will be included in the BSPs but IDT will review behaviors weekly to ensure they BSP's are revised when needed to include the most up to date information.</p>		

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	<p>"Housemate [client D] returned from work and was eating dinner. [Client A] was sitting at the table with him, housemate [client B] was also around the table. [Client A] told [client B] to stop looking at [client D] ([client A's] boyfriend). [Client B] did not stop looking at [client D]. [Client A] got upset and pushed [client B] back to her room in her wheelchair. [Client A] then punched [client B] in the ear and shoulder and kicked her in the back. [Client A] knocked [client B's] pictures down and broke the frames. Staff went back to room (sic) and got [client A] out of the room...[Client B] decided to file a police report. The police came out and took statements from all housemates and [client B] was taken to the ER (Emergency Room) per [client B's] request. [Client A] and [client B] (sic) away from each other as much as possible. Staff should keep [client A] in line of sight until further notice. Behavior specialist was notified of incident."</p> <p>Client A's record was reviewed on 10/01/13 at 2:00 PM. Incident reports indicated client A exhibited physical aggression on the following dates toward her housemates (clients B, C, D and G) on: 02/12/13, 03/4/13, 03/12/13, 03/14/13, 04/25/13 and 06/4/13.</p>						

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	<p>Client A's updated BSP of 3/11/13 indicated the BS (Behavior Specialist) "removed elopement and physical aggression from targeted behaviors." Client A's BSP indicated client A had targeted behaviors of depressive characteristics and emotional outbursts. The BSP defined emotional outbursts to be "yelling, cussing, threatening, stomping, ignoring/refusing to talk to those with whom she is angry, slamming doors or other objects (including her own hand, head, etc. against something), minor hitting, and property destruction (such as throwing her own belongings)." The BSP indicated reactive strategies to client A's emotional outbursts to be: "Continue to use a calm voice and react calmly. Watch for signs of [client A] beginning to get upset.... encourage her to use her coping strategies such as taking a break in a safe place, deep breathing, music, relaxation exercises, talking about it with someone appropriate, journaling, etc. to calm herself.... Compliment her when she calms down using one of her coping strategies.... If [client A] begins to get agitated by yelling, cussing, threatening, stomping, slamming items, etc., clear the environment of people and items that would be unsafe. Redirect her to a safe place away from others where she can calm down. [Client A] usually chooses to go to her room if at home. Encourage her</p>			

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	<p>to use her self-calming strategies. [Client A] may come out when she is calm.... Check on [client A] after 30 minutes to make sure she is safe....Talk through the issue once she is calm." Client A's BSP did not address client A's identified behavior of physical aggression.</p> <p>During interview with client D on 10/01/13 at 4:30 PM, client D stated "Oh yeah, she [client A] gets physically aggressive all the time. I don't think she aims to, but she does." Client D stated client A "often gets mad" and would hit him and/or other clients in the group home.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) on 10/03/13 at 12:30 PM indicated client A's BSP indicated target behaviors of depressive characteristics and emotional outbursts. The QIDP indicated client A's BSP did not address client A's identified behavior of physical aggression.</p> <p>2. Client C's record was reviewed on 10/01/13 at 4:00 PM. Incident reports indicated client C exhibited refusal behavior on the following dates: 08/21/13, 09/24/13, 09/26/13, 09/27/13, 09/27/13 and 09/28/13.</p> <p>Client C's BSP dated 01/15/13 indicated</p>						

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	<p>client C's behaviors included: "excessive irritability and leaves without asking." The BSP did not include refusals and what staff were to do if client C refused to comply with a request or program implementation.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) on 10/03/13 at 12:30 PM indicated client C's BSP did not include refusals or what staff were to do if client C refused to comply with a request or programming. The QIDP indicated this behavior was not being tracked or recorded.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. 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	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.	W000312	In regard to W312, titration plans for medications 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 oversee this committee. Both BSP's have been updates and staff will be trained by corrected date. 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	11/03/2013	

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	<p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients A and B) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plans (BSPs) included the medication or a titration plan for the medications in the plan.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 10/01/13 at 2:00 PM. Client A's 09/01/13 physician's orders indicated client A took Lexapro 10 mg (milligrams) a day and Klonopin 0.5 mg twice a day for behavior modification. Client A's updated BSP (Behavior Support Plan) of 3/11/13 indicated client A had targeted behaviors of depressive characteristics and emotional outbursts. Client A's BSP indicated a "Medication reduction statement: [Client A's] current psychotropic medication is monitored by psychiatrist [name of psychiatrist] with [name of physician's network] in [name of city]. [Client A] and her IDT (Interdisciplinary Team) maintain responsibility for all changes in medication. Behavior data is collected to monitor changes in behavior. This data is</p>		11/7/2013. Prior to this, there was not a titration plan.				

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	<p>to provide information to [client A's] MD (medical doctor) to consider a medication reduction plan at each 90 day medication review. [Client A's] team has expressed that the medications currently prescribed are necessary and appropriate for [client A] at this time. Should [client A] demonstrate marked improvement in her depression, anxiety, and irritability as evidenced by having 6 months free of one of these behaviors, the team may consider making an appointment with her MD to consider a titration plan. This document will be reviewed by the Human Rights Committee upon each change in psychotropic medication."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/2/13 at 11 AM indicated client A's medication reduction plan was not specific to the client A's behaviors for which each psychoactive medication was to target.</p> <p>2. Client B's records were reviewed on 10/01/13 at 3:00 PM. Client B's BSP dated 08/27/13 indicated client B's diagnosis included anxiety and her behaviors included communicating inaccurate information, refusals and urinating in a non-toilet location. The BSP indicated client B was on Zoloft for anxiety. The BSP indicated, "...Should</p>						

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	<p>[client B] demonstrate marked improvement in her anxiety as evidenced by having a 50% reduction from baseline over 6 months of her anxiety...the team may consider making an appointment with her MD to consider a reduction of the dosage of the medication...." The BSP did not indicate what the "baseline" was for client B.</p> <p>On 10/04/13 at 12:10 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client B'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 #IN00132706.</p> <p>This deficiency was cited on 08/09/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p>				

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W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) to have an annual physical examination.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/01/13 at 2:00 PM. Client A's last recorded annual physical was conducted in 1/2012.</p> <p>On 10/04/13 at 12:10 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN stated she "thought" client A had an annual physical, but she could not locate any documentation after the one on 01/2012.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>	W000322	In regard to W322, client did not have annual physical paperwork completed at her yearly dr appointment, dr said that the client did not need one, so staff did not schedule. The nurse informed staff that all clients need annual physicals. The nurse is responsible to keep a master schedule of all needed appointments. The appointments will be reviewed monthly in QA. All appointments are now being put in to a master schedule that states the reason for appointment. The PC and QIDP will then know what needs filled out for each appointment and will prepare the paperwork for the staff ahead of time. The COC's are being brought immediately to the administrative office for scanning to nurse so that the nurse will immediately know what to follow up on and what paperwork to have. Previously they were not always being brought to the office, so if there was paperwork for follow up, it was not immediately completed. Staff have been trained. Nurse will oversee all paperwork and COC's.	11/03/2013			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W000331	In regard to W331, ASI failed to have a plan for client to be out of wheelchair and using walker. Client is out of wheelchair daily but it is on an informal basis, not following a plan. A plan has been put in place for client to follow and staff remind her so that we are meeting her PT recommendations In regard to skin integrity, both clients should have had skin checks in place with tracking due to ambulation and gout. Those are in place. Both clients were missing quarterly fall risk assessments. Those have been completed. All appointments are now being put in to a master schedule that states the reason for appointment. The PC and QIDP will then know what needs filled out for each appointment and will prepare the paperwork for the staff ahead of time. The COC's are being brought immediately to the administrative office for scanning to nurse so that the nurse will immediately know what to follow up on and what paperwork to have. The nurse is responsible for the protocol/procedures needing developed from all appointments and diagnosis. The nurse is also responsible for monthly, quarterly and annual reviews. RN monthly oversight will allow for	11/03/2013	

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	<p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients B and C), by not ensuring clients received nursing services according to their medical needs: by failing to ensure client B had a plan for when she was to be out of the wheelchair and when she was to use her walker; by failing to monitor and document the skin integrity of clients B and C; by failing to ensure client C's prescribed diet was followed and menu portion size addressed and by failing to have a fall risk plan for client C.</p> <p>Findings include:</p> <p>1. Client B's records which were located at the agency were reviewed on 10/01/13 at 3:00 PM. Client B's 04/23/13 ISP (Individual Support Plan) indicated client B used a wheelchair and her diagnoses included but were not limited to Cerebral Palsy and Moderate Spastic Paresis (paralysis). Client B's record review included review of the following dated documents:</p>		<p>quality checks to be done for nursing protocols/ procedures to ensure we have appropriate and required ones in place. Findings will be reviewed/addressed in monthly quality assurance meetings.</p>		

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	<p>08/08/12: A Continuity Of Care Form indicated she was seen by PT (Physical Therapy) for evaluation of ambulation, transfer and exercise training. The PT recommendation indicated, "Increase time out of the wheelchair with standing walking and laying (sic) bed with leg straight."</p> <p>01/31/13: A Continuity Of Care Form indicated client C was seen by PT. The form indicated PT for, "ambulation/transfer training, stand/seating balance, (unable to read) stretches to B (bilateral) hip flexors."</p> <p>Client B's records in the home were reviewed on 10/03/13 at 4:15 PM. 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. Client B's record did not contain skin integrity monitoring or a schedule of when she should be in or out of her wheelchair.</p> <p>An interview was conducted on 10/03/13 at 4:18 PM with staff #3. Staff #3 indicated client B's goal book was the only record they had. She indicated the book did not contain a fall risk plan or instructions on when, how or what staff</p>						

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	<p>were to do to regarding ambulation instructions or an ambulation plan for client B. Client B's record did not contain skin integrity monitoring or a schedule when she should be in or out of her wheelchair.</p> <p>On 10/04/13 at 12:10 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the agency had been working at getting the risk plans completed and in the books, but some of them had not been completed. She stated client B's plans were in her medical file at the agency but it "apparently" was not in the group home yet.</p> <p>2. Client C's records were reviewed on 10/01/13 at 4:00 PM. Client C's 04/23/13 ISP (Individual Support Plan) indicated client C's diagnosis included but was not limited to Gout. Client C's record review included review of the following dated documents:</p> <p>05/31/13: A Continuity of Care Form indicated client C had seen the podiatrist. The podiatrist indicated, "Pt (patient) limping with unsteady gait, 'holds the wall' when walking. Recommended AFO (ankle-foot orthotic) B (bilaterally), because (sic) weakness...."</p>			

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	<p>Client C's record did not contain an updated fall risk assessment or plan related to the unsteady gait. Client C's record did not contain daily skin integrity monitoring and documentation related to monitoring of his Gout.</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 C was at risk for falls, and a fall risk plan had not been completed. She indicated client C did not have skin integrity monitoring documentation in place and he was at risk for skin breakdown due to his gout and therefore his skin should be monitored and documented on daily.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				

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W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 3 of 3 sampled clients (clients A, B and C) and 4 additional clients (clients D, E, F and G), the facility failed to ensure a clean area for the clients to eat their meals</p>	W000454	In regard to W454, ASI failed to ensure a clean area for clients to eat and to drink from glasses not touched by others. Staff have been retrained on procedures for sanitation. Weekly site checks will provide quality assurance Observing meals is a visitation topic and management will provide training when needed to address issues with protocols/ procedures. The Safety committee will review site visitations weekly to ensure issue are being addressed. Nurse is responsible for training staff on dining protocol and procedures and all trainings are monitored by our records admin assistant. Any staff not attending needed and required trainings are taken off shift until they have completed trainings. In response to the letter dated November 14, 2013, weekly site checks include a minimum of three site checks a week. These can be announced or unannounced and include a site check for what is completed to show areas checked.	11/03/2013	

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	<p>and to drink from glasses not touched by others.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 10/01/13 from 3:29 PM until 5:30 PM and staff #1 and #2 were on duty. Client D sat at the dining room table at 3:51 PM and had a binder and papers spread about the table. At 4:15 PM client D gathered up the papers and binder and left the table. At 4:20 PM client D returned to the table, laid an exercise band on the table, then picked up the band and used it to do his leg exercises. At 4:53 PM client A went from her bedroom into the kitchen, obtained glasses from the cabinet and touching the top edges of the glasses, placed six glasses around the table for each of the clients. At 4:54 PM client D placed plates around the table for each of the clients. At 5:08 PM clients A, B, C, D, E and F went to the table without washing their hands or being prompted to wash their hands before supper. The dining room table was not cleaned prior to being set. Clients A, B, C, D, E and F drank from the glasses client A touched with her hands on the rims.</p> <p>On 10/04/13 at 12:10 PM an interview with the LPN (Licensed Practical Nurse)</p>						

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	<p>was conducted. The LPN indicated clients should wash their hands prior to setting the table and sitting down for supper. She also indicated the table should have been cleaned before the table was set. She further indicated client A should not have touched the top of the glass where other clients would be drinking.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>This deficiency was cited on 08/09/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>			

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sample clients (client C) who was on a modified diet to ensure diet orders were followed.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 10/01/13 from 3:29 PM until 5:30 PM and staff #1 and #2 were on duty. Client C went to the supper table at 5:15 PM and spooned food on his plate. Supper included salisbury steak, mashed</p>	W000460	<p>In regard to W460, ASI failed to follow the prescribed diet for a client. ASI was in the process of contracting with a new dietician, and had not received information for client. This is corrected. Dietician plans will be reviewed quarterly by Quality Assurance Committee to ensure the diets are accurate and updated for each client at each home. Nurse is responsible for training staff and all trainings are monitored by our records admin assistant. Any staff not attending needed and required trainings are taken off shift until they have completed trainings.</p>	11/03/2013	

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	<p>potatoes, gravy, spinach, bread and margarine. Client C's meat was not weighed or the margarine measured for portion.</p> <p>Client C's records were reviewed on 10/01/13 at 4:30 PM. Client D's September 2013 Physician's Orders indicated client C was on a 2000 calorie ADA (American Diabetic Association) diet.</p> <p>An interview was conducted on 10/01/13 with staff #2 at 4:50 PM. Staff #2 indicated the posted diet was a regular diet menu and all of the clients except client A were on a regular diet.</p> <p>On 10/04/13 at 12:10 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the agency had contracted with a new dietitian who had just started this week. She indicated client C was not on a regular diet and he should have one posted in the home to follow. She indicated client C's diet could only be monitored to ensure he was getting a 2000 calorie ADA diet if the diet was available in the home and the portions were weighed and measured for accuracy.</p> <p>This federal tag relates to complaint #IN00132706.</p>						

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	<p>This deficiency was cited on 08/09/13.</p> <p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>			