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 12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILITIES SERVICES INC	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	This visit was for a full annual recertification and state licensure survey. Dates of Survey: November 12, 13, 14, 15 and December 11, 2013. Facility number: 005592 Provider number: 15G736 AIM number: 200859130 Surveyor: Christine Colon, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/20/13 by Ruth Shackelford, QIDP.	W000000		
W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on interview and record review, the facility failed to meet the Condition	W000102	In regard to W0102, a review of all nursing services provided to each consumer has been	01/10/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	of Participation: Governing Body for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6). The governing body failed to ensure the facility implemented its policy and procedures to protect the clients' rights by preventing abuse/neglect. The governing body neglected to ensure the facility immediately reported incidents of abuse/neglect and failed to report the results of the investigations. The governing body neglected to ensure the facility put corrective measures in place to prevent abuse and neglect. Findings include: 1. Please refer to W122: The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6). The governing body failed to implement its written policies and procedures to prevent abuse of clients. The facility failed to immediately report incidents of abuse/neglect and failed to report the results of the findings. The governing body failed to put in place sufficient/effective corrective measures to prevent abuse/neglect.		completed and any missing information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented. In regard to ensuring the facility	

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	2. Please refer to W104: The governing body failed for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented. The governing body failed to immediately report incidents of abuse/neglect and failed to report the results of the findings. 3. Please refer to W318: The Condition of Participation, Health Care Services, is not met as the governing body failed to provide adequate nursing services for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6). 9-3-1(a)		implemented its policy and procedures to protect the clients rights by preventing abuse/neglect/exploitation, The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. 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. 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	

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			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 investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In 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.	
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview,	W000104	In regard to W0104,ensuring the	01/10/2014

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	the governing body failed for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented. Findings include: A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigation records was conducted on 11/12/13 at 11:15 A.M.. Review of the facility's investigation records indicated: 1. -Investigation (no date noted) involving client #1 indicated: Statement from Nurse: "I received an incident report that two of [client #1]'s valium 2.5 mg (milligram) had been popped out due to a seal being broken and they were destroyed on Friday 6/21. [Staff #1] sent [Staff #2] over to look for the pills and they were not there. [Staff #1] and I (Nurse) went over on Tuesday 6/25 with [Staff #2] and the pills were not there. We requested per [Staff #4] to have [Direct Support Professional (DSP) #10] come into (sic) find the pills. She could not find the pills and was told to call [Staff #4]." Statement from Program Coordinator (PC) dated 6/27/13: "On		facility implemented its policy and procedures to protect the clients rights by preventing abuse/neglect/exploitation, The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. 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. 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	

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	Friday, June 21, 2013 following the staff meeting, [DSP #10] was doing Narc count in the kitchen. She brought to me a bubble pack of [client #1]'s Valium 2.5 mg (yellow half pills) and showed me that 2 of the seals were broken (looking on the back it was the right hand column-mid way down-not sure which 2 specific bubbles). I confirmed that they were broken. I told her to proceed with destroying them. I left the house as she went back into the kitchen to finish Narc count. I was not there when she finished the count/destruction. I worked at (sic) 12 hour shift on Saturday. I did not pass meds during that shift. Therefore I did not get into the med cabinets. I did not see any red bags or medications anywhere else in the house." Notes on investigation indicated: "7/1/13...Left message on her voicemail (DSP #10)...7/2/13: [DSP #10] called and left message...7/2/13: I explained that with her refusal to go for screening on Friday/Monday we had no choice but to assume it as positive and proceed with termination...." Further review of the record did not indicate the results of the investigation were reported to the administrator within 5 days. -Investigation dated 10/14/13 involving client #1 indicated: "Date Investigation begins: 10/14/13...Date Investigation		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 investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In 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.	

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	completed: 10/23/13...Name of Alleged Victim: [Client #1]...Staff were getting ready to change [client #1]. [Staff #25] left the room to get pants out of the dryer for [client #1]. [Staff #25] knocked on door and [Staff #26] put bed rail up to answer the door. When she reached the door they heard a boom. [Client #1] had rolled and fallen off the bed...Small cut above the eye, hip pain...Staff left [client #1] to open door. She fell off changing table....Bed rail was checked by staff, bed rail gave out. New rail was bought and replaced immediately. Staff must be within arms length when changing." Further review of the record did not indicate the results of the investigation were reported to the administrator within 5 days. 2. Investigation records involving client #3's elopements and staff neglecting to implement his line of sight protocol indicated: -Investigation dated 2/21/13 involving client #3 indicated: "Statement from DSP #13: I was discussing with [DSP #14] about when she wanted me to put on a change of clothes for [Client #5]. I was about to do that when I heard the alarm for the front door. [DSP #14] told me [client #3] had gone through the front door. [Staff name] asked me to go			

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	out to try to coax him back in. He was in [DSP #15]'s vehicle. I was able to walk him back into the building through the back door with [DSP #15]'s assistance....Statement from DSP #16: This writer had just completed changing [client #1]'s and others wet clothing in the washer machine, started the washer machine to going when [DSP #13] yelled '[client #3] went out the door." -Investigation dated 4/26/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Not following BSP line of sight...Summary of findings: Staff did not follow line of sight protocol....4/25/13-Incident-[Client #3]...Timeline: Elopement: At 5:24 P.M.-staff went to get [client #3] from his room for dinner. He was not there. [DSP #20] made an immediate call to [DSP #21], who was still in the area. [DSP #21] told her to call [PC]. [DSP #20] phoned [PC] as she was walking outside to look for [client #3]. She got in her car as [PC] told her he might be at the track since the high school track is right behind the group home and there was an event going on. She drove about 10 feet and saw him at the track. She saw [DSP #21] running in to the track field to get him. [DSP #21] got to him, he was fine, just walking around the track. She assisted him to the group			

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	home. He was checked for any injuries. Nothing found." -Investigation dated 5/9/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Neglect-Elopement of consumer...Not following line of sight protocol...Summary of Findings: [Client #3] was to be in line of sight of [DSP #13] b/c (because) he was assigned to [DSP #13]'s group...[DSP #13] received disciplinary action. Statement from [DSP #30]: At approximately 2:30 on 5/8/13 [DSP #30] was in the office asking [DSP #31] a question and she heard the alarm sound. She looked out and staff all appeared busy and she did not see [client #3] anywhere. She went and looked out front and he was standing by [Staff name]'s jeep. Once she saw him out there, she yelled and went out after him. [DSP #31] ran out after [DSP #30]. Staff were able to get him back inside." -Investigation dated 6/3/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Neglect-Elopement of consumer. Not following line of sight protocol...Summary of findings: Staff did not follow line of sight protocol...Recommendations: All staff			

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	receive verbal warning due to schedules not passed. Staff were verbally told groups they have. PC and Assistant have been trained to give schedules....The morning of 6/3/13, [PC] was in front of my desk talking to me. Out of the corner of my eye I seen (sic) [client #3] walked pass (sic) the glass windows along the north side of the building. At that time [PC] saw [client #3] and said 'There [client #3], who is with him?' We realized that no one was with [client #3]. [PC] took out the front door and headed [client #3] off. I looked to the back door to see if it was open or if anyone was around. The door was shut and no (sic) was near the back door. I walked to the window to see if [PC] caught up with [client #3] and yell for staff if I needed to call for help. [PC] caught up with [client #3] by the front entrance. [Client #3] kept walking down the steps and was halted by [PC] at the bottom of the steps on the west side of the building (front parking lot). I walked around to help [PC] when [Staff name] went out the front door after [client #3]. I didn't go outside to help [PC] but started to go to let [DSP #35] know that [client #3] was outside. I told [DSP #36] that [PC] got him and I went back to the window to see if everything was alright. [PC] and [Staff name] were still with [client #3] at the bottom of the			

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	steps on the east side of the building. When staff headed out the front door to assist them with [client #3]. I return to work on my computer and continued working. After 5 to 8 minutes [client #3] strolled back into the facility followed by [PC]." A review of client #3's record was conducted on 11/13/13 at 2:44 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 #3] on a more restrictive Watchful Eye Protocol. [Client #3] should be in staff's LINE OF SIGHT AT ALL TIMES. The only exception to this is when [client #3] 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 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 #3] is			

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	in the backyard, staff should be outside with him to ensure that he has not left the area through the fence." 3. -BDDS report dated 2/23/13...Date of Knowledge: 2/23/13...Submitted Date: 2/25/13 indicated: "Staff was going to give [client #6] a shower and staff noticed bruises on [client #6]'s left and right thigh. [Client #3] said he fell, he also said 'don't hurt me' when staff when (sic) to examine the bruises. Nothing violent was happening to warrant that statement . [Client #3] seemed like he didn't want to talk about it. He was looking down and his voice got quieter. Staff contacted Qualified Developmental Disabilities Professional (QDDP), QDDP contacted [Program Coordinator (PC)] and [Nurse]. QDDP had staff document everything for the rest of the weekend. The reason this is filed late is due to the fact that the QDDP and PC wanted to talk with [client #6] in person Monday morning to find out what happened. Per QDDP and PC conversation with [client #6] he stated that his mom was changing him after he peed on her couch. She was mad at him and that is how he got the bruises...." Review of the record failed to indicate the administrator was immediately notified of the unknown injury.			

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	-BDDS report dated 3/6/13...Date of Knowledge: 3/8/13...Submitted Date: 3/8/13 indicated: "Staff was lifting [client #6] into bed and [client #6] had a blister on his toe. When staff layed (sic) him down his blister was scraped off." The investigation record for this incident indicated: "QDDP was notified 2 days after blister was noticed. Nurse was notified that day....He was wearing his boots instead of tennis shoes. Caused toe to rub and blister....High risk (skin break down from wearing leg braces) states he is to wear tennis shoes with his braces." 4. -Investigation record dated 4/18/13 indicated: "Staff did not follow behavior plan and chose to put [client #6] in 'time out' and allowed him to sit facing the wall in his wheelchair for 40 minutes. He was also sitting the entire time in soiled (wet) pants. Staff was aware of this...Recommendations: Termination." -Investigation record dated 8/1/13 indicated: "Staff stated that she told [client #6] it was lunch time and he started whining and didn't want to come over to lunch area and kept whining. She told him to shut up and come over. She asked what she should have said instead. I told her she should allow him			

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	space and tell him when he was ready to let her know or come over. Verbal warning Discussion/training on how to encourage consumers and not using verbally abusive words/tone." -Investigation record dated 8/29/13 indicated: "Alleged Abuse/Neglect/Exploitation: Leaving consumer (client #6) in vehicle while going into store. Staff left [client #6] in car at [Store name] for approximately 3 minutes with the car running and locked to go to the bathroom. Staff receive a written warning for this incident." -Investigation record dated 9/24/13 indicated: "Names of alleged victims: [Client #1], [Client #2], [Client #3], [Client #4], [Client #5] and [Client #6]...Date/Time BDDS report filed: 9/24/13: September 22, 2013-overnight shift-[DSP #35] working with [DSP #36]. [DSP #26] stated that [DSP #35] slept on shift . [DSP #36] also stated that [DSP #35]'s tone is loud and abrupt to the consumers. [DSP #36] stated that in the last 2 weeks, [DSP #35] has slept on shift when she has worked with her and that is approximately 4 times in the last 2 weeks that she has worked with her...Summary of Incident: [DSP #35] has slept on shift. It is not determined how long she was asleep, but that is			

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	irrelevant. Sleeping on shift is prohibited. Two staff is (sic) scheduled on shift for care of consumers and line of sight protocol. Both staff and consumer identified an incident of staff [DSP #35] sleeping. It is found through the investigation [DSP #35]'s voice/tone is regularly described as loud and abrupt and direct...In addition to [DSP #35] disciplinary action-It is recommended that [DSP #36] receive a verbal warning for failing to immediately report any allegations of abuse, neglect, allegations." -Investigation record dated 10/28/13 indicated: "[DSP #19] was working with [DSP #17] on second shift. [DSP #19] went to office and sat in chair and fell asleep. [DSP #17] was working. All consumers were in bed. She thought [DSP #19] had gone outside for a break. [DSP #17] found her in the office asleep and tried to wake her. She could not. Third shift woke her. [DSP #19] admitted to falling asleep." Further review did not indicate what corrective action was put in place to prevent recurrence. A review of the facility's abuse and neglect policy dated 12/12 was conducted on 11/14/13 at 7:30 P.M.. Review of the policy indicated:			

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	"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 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			

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	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." An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 5:30 P.M.. The PC 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 PC indicated they were not. The PC indicated all incidents of abuse and neglect are to be immediately reported to the administrator and within 24 hours to BDDS. The PC indicated all incidents should be investigated and the results are to be reported to the administrator within 5 days. 9-3-1(a)			

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6). The facility failed to implement its written policies and procedures to prevent abuse/neglect of clients. The facility failed to immediately report incidents of abuse/neglect and failed to report the results of the investigations within 5 days. The facility failed to put in place sufficient/effective corrective measures to prevent potential abuse/neglect. Findings include: 1. Please refer to W149: The facility neglected for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6) to implement written policy and procedures to prevent alleged abuse/neglect.	W000122	In regard to W-0122, ensuring the facility implemented its policy and procedures to protect the clients rights by preventing abuse/neglect/exploitation, The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. 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	01/10/2014

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	2. Please refer to W153: The facility failed for 1 additional client (client #6), to report suspected abuse immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. 3. Please refer to W156: The facility failed to report the results of 2 of 13 reviewed investigations, involving 1 of 3 sampled clients (client #1), to the administrator within five business days. 4. Please refer to W157: The facility failed for 1 of 3 sampled clients (client #3), to take sufficient/effective corrective measures in regard to client #3's elopement. 9-3-2(a)		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 investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse,	

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			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.	
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (client #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6) to have toilet paper, paper towels, and hand soap readily accessible in the restroom. Findings include: A morning observation was conducted at the group on 11/12/13 from 6:30 A.M. until 9:00 A.M.. During the entire observation period both bathrooms at clients #1, #2, #3, #4, #5 and #6's home had no toilet paper, paper towels/towels or hand soap available for use. An evening observation was conducted at the group on 11/12/13 from 3:45 P.M. until 6:00 P.M.. During the entire	W000125	In regard to W125, consumers did not have access to toilet paper, paper towel and hand soap in the bathrooms. This has been corrected. The problem stemmed from staff trying to keep full toilet paper rolls and paper towels being stuffed in to the toilets by consumers and making individual decisions to put toilet paper under the sink or giving rolls of toilet paper to consumers as they wenet to the bathroom. All staff are trained on consumers rights during orientation, annual recertification and during med core. Monthly site checks will check for possible rights violations and will be reviewed by safety committee at bi-monthly meetings and oversight of any action needed will be provided by safety chairperson - Director of Programming. To address this issue, staff have been re-trained	01/10/2014

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	observation period both bathrooms at the group home had no toilet paper, paper towels/towels or hand soap available for use. An interview with Direct Support Professional (DSP) #6 was conducted on 11/12/13 at 4:00 P.M.. DSP #6 indicated the toilet paper, hand soap, and paper towels were not kept in the bathroom due to clients #3 and #4 wasting them. An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 2:15 P.M.. The PC indicated the toilet paper, paper towels and hand soap should be out for clients to see and have access to. 9-3-2(a)		on consumer rights and that any restrictions cannot be put into place without approval from the Human Rights Committee. Compliance with consumer rights will be monitored by the QIDP and Program Coordinator when they are in the homes. ASI has set procedures for unnounced and announced site visites by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and Staffing. Each visit will have a site visitation form to be completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly.	
W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, the facility failed for 1 additional client	W000130	In regard to W130, consumers must receive privacy during treatment and care	01/10/2014

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	(client #5) to ensure privacy while using the toilet. Findings include: An evening observation was conducted at the group home on 11/12/13 from 3:45 P.M. until 6:00 P.M.. At 3:55 P.M., client #5 sat on the toilet with the bathroom door open. At 4:15 P.M., client #5 stood up, took off all of his clothing and sat back on the toilet, while the bathroom door was open. At 4:20 P.M., Direct Support Professionals (DSP) #4 and #5 walked past the bathroom where client #5 sat naked on the toilet and did not prompt him to close the door and did not close the door. There was no training regarding privacy observed while client #5 used the toilet. An interview with DSP #4 was conducted on 11/12/13 at 4:30 P.M.. DSP #4 indicated the bathroom door is left open while client #5 uses the toilet so staff can keep an eye on him. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 11/13/13 at 2:15 P.M.. The QIDP indicated all		of personal needs. This has been corrected. Staff have been re-trained to prompt consumers to shut the door when in the bathroom and to shut the door if a consumer goes in and fails to shut the door. All staff are trained on consumers rights during orientation, annual recertification and during med core. Monthly site checks will check for possible rights violations and will be reviewed by safety committee at bi-monthly meetings and oversight of any action needed will be provided by safety chairperson - Director of Programming. To address this issue, staff have been re-trained on consumer rights and that any restrictions cannot be put into place without approval from the Human Rights Committee. Compliance with consumer rights will be monitored by the QIDP and Program Coordinator when they are in the homes. ASI has set procedures for unannounced and announced site visites by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and Staffing. Each visit will have a site visitation form to be	

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	clients should have privacy while using the bathroom. 9-3-2(a)		completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly.	
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 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), the facility neglected to implement written policy and procedures to prevent alleged abuse. Findings include: A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigation records was conducted on 11/12/13 at 11:15 A.M.. Review of the records indicated: 1. -Investigation (no date noted) involving client #1 indicated: Statement from Nurse: "I received an incident report that two of [client #1]'s valium 2.5 mg (milligram) had been popped out due to a seal being broken and they were destroyed on Friday 6/21. [Staff #1]	W000149	In regard to ensuring the facility implemented its policy and procedures to protect the clients rights by preventing abuse/neglect/exploitation, The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. 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	01/10/2014

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	sent [Staff #2] over to look for the pills and they were not there. [Staff #1] and I (Nurse) went over on Tuesday 6/25 with [Staff #2] and the pills were not there. We requested per [Staff #4] to have [Direct Support Professional (DSP) #10] come into (sic) find the pills. She could not find the pills and was told to call [Staff #4]." Statement from Program Coordinator (PC)dated 6/27/13: "On Friday, June 21, 2013 following the staff meeting, [DSP #10] was doing Narc count in the kitchen. She brought to me a bubble pack of [client #1]'s Valium 2.5 mg (yellow half pills) and showed me that 2 of the seals were broken (looking on the back it was the right hand column-mid way down-not sure which 2 specific bubbles). I confirmed that they were broken. I told her to proceed with destroying them. I left the house as she went back into the kitchen to finish Narc count. I was not there when she finished the count/destruction. I worked at (sic) 12 hour shift on Saturday. I did not pass meds during that shift. Therefore I did not get into the med cabinets. I did not see any red bags or medications anywhere else in the house." Notes on investigation indicated: "7/1/13...Left message on her voicemail (DSP #10)...7/2/13: [DSP #10] called and left message...7/2/13: I explained that with her refusal to go for screening on		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 investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is	

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	Friday/Monday we had no choice but to assume it as positive and proceed with termination...." Further review of the record did not indicate the results of the investigation were reported to the administrator within 5 days. -Investigation dated 10/14/13 involving client #1 indicated: "Date Investigation begins: 10/14/13...Date Investigation completed: 10/23/13...Name of Alleged Victim: [Client #1]...Staff were getting ready to change [client #1]. [Staff #25] left the room to get pants out of the dryer for [client #1]. [Staff #25] knocked on door and [Staff #26] put bed rail up to answer the door. When she reached the door they heard a boom. [Client #1] had rolled and fallen off the bed...Small cut above the eye, hip pain...Staff left [client #1] to open door. She fell off changing table....Bed rail was checked by staff, bed rail gave out. New rail was bought and replaced immediately. Staff must be within arms length when changing." Further review of the record did not indicate the results of the investigation were reported to the administrator within 5 days. 2. Investigation records involving client #3's elopements and staff neglecting to implement his line of sight protocol indicated:		on this committee. 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.	

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	-Investigation dated 2/21/13 involving client #3 indicated: "Statement from DSP #13: I was discussing with [DSP #14] about when she wanted me to put on a change of clothes for [Client #5]. I was about to do that when I heard the alarm for the front door. [DSP #14] told me [client #3] had gone through the front door. [Staff name] asked me to go out to try to coax him back in. He was in [DSP #15]'s vehicle. I was able to walk him back into the building through the back door with [DSP #15]'s assistance....Statement from DSP #16: This writer had just completed changing [client #1]'s and others wet clothing in the washer machine, started the washer machine to going when [DSP #13] yelled '[client #3] went out the door." -Investigation dated 4/26/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Not following BSP line of sight...Summary of findings: Staff did not follow line of sight protocol....4/25/13-Incident-[Client #3]...Timeline: Elopement: At 5:24 P.M.-staff went to get [client #3] from his room for dinner. He was not there. [DSP #20] made an immediate call to [DSP #21], who was still in the area. [DSP #21] told her to call [PC]. [DSP #20] phoned [PC] as she was walking			

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	outside to look for [client #3]. She got in her car as [PC] told her he might be at the track since the high school track is right behind the group home and there was an event going on. She drove about 10 feet and saw him at the track. She saw [DSP #21] running in to the track field to get him. [DSP #21] got to him, he was fine, just walking around the track. She assisted him to the group home. He was checked for any injuries. Nothing found." -Investigation dated 5/9/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Neglect-Elopement of consumer...Not following line of sight protocol...Summary of Findings: [Client #3] was to be in line of sight of [DSP #13] b/c (because) he was assigned to [DSP #13]'s group...[DSP #13] received disciplinary action. Statement from [DSP #30]: At approximately 2:30 on 5/8/13 [DSP #30] was in the office asking [DSP #31] a question and she heard the alarm sound. She looked out and staff all appeared busy and she did not see [client #3] anywhere. She went and looked out front and he was standing by [Staff name]'s jeep. Once she saw him out there, she yelled and went out after him. [DSP #31] ran out after [DSP #30]. Staff were able to get			

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	him back inside." -Investigation dated 6/3/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Neglect-Elopement of consumer. Not following line of sight protocol...Summary of findings: Staff did not follow line of sight protocol...Recommendations: All staff receive verbal warning due to schedules not passed. Staff were verbally told groups they have. PC and Assistant have been trained to give schedules....The morning of 6/3/13, [PC] was in front of my desk talking to me. Out of the corner of my eye I seen (sic) [client #3] walked pass (sic) the glass windows along the north side of the building. At that time [PC] saw [client #3] and said 'There [client #3], who is with him?' We realized that no one was with [client #3]. [PC] took out the front door and headed [client #3] off. I looked to the back door to see if it was open or if anyone was around. The door was shut and no (sic) was near the back door. I walked to the window to see if [PC] caught up with [client #3] and yell for staff if I needed to call for help. [PC] caught up with [client #3] by the front entrance. [Client #3] kept walking down the steps and was halted by [PC] at the bottom of the steps on the west			

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	side of the building (front parking lot). I walked around to help [PC] when [Staff name] went out the front door after [client #3]. I didn't go outside to help [PC] but started to go to let [DSP #35] know that [client #3] was outside. I told [DSP #36] that [PC] got him and I went back to the window to see if everything was alright. [PC] and [Staff name] were still with [client #3] at the bottom of the steps on the east side of the building. When staff headed out the front door to assist them with [client #3]. I return to work on my computer and continued working. After 5 to 8 minutes [client #3] strolled back into the facility followed by [PC]." A review of client #3's record was conducted on 11/13/13 at 2:44 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 #3] on a more restrictive Watchful Eye Protocol. [Client #3] should be in staff's LINE OF SIGHT AT ALL TIMES. The only exception to this is when [client #3] is in the bathroom or bedroom; staff			

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	should ensure that he is in one of these locations initially and then do 2-3 minute checks to 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 #3] is in the backyard, staff should be outside with him to ensure that he has not left the area through the fence." 3. -BDDS report dated 2/23/13...Date of Knowledge: 2/23/13...Submitted Date: 2/25/13 indicated: "Staff was going to give [client #6] a shower and staff noticed bruises on [client #6]'s left and right thigh. [Client #3] said he fell, he also said 'don't hurt me' when staff when (sic) to examine the bruises. Nothing violent was happening to warrant that statement . [Client #3] seemed like he didn't want to talk about it. He was looking down and his voice got quieter. Staff contacted Qualified Developmental Disabilities Professional (QDDP), QDDP contacted [Program Coordinator (PC)] and [Nurse]. QDDP had staff document everything for the rest of the weekend. The reason this is filed late is due to the fact that the QDDP and PC wanted to talk with [client #6] in person			

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	Monday morning to find out what happened. Per QDDP and PC conversation with [client #6] he stated that his mom was changing him after he peed on her couch. She was mad at him and that is how he got the bruises...." Review of the record failed to indicate the administrator was immediately notified of the unknown injury. -BDDS report dated 3/6/13...Date of Knowledge: 3/8/13...Submitted Date: 3/8/13 indicated: "Staff was lifting [client #6] into bed and [client #6] had a blister on his toe. When staff layed (sic) him down his blister was scraped off." The investigation record for this incident indicated: "QDDP was notified 2 days after blister was noticed. Nurse was notified that day....He was wearing his boots instead of tennis shoes. Caused toe to rub and blister....High risk (skin break down from wearing leg braces) states he is to wear tennis shoes with his braces." 4. -Investigation record dated 4/18/13 indicated: "Staff did not follow behavior plan and chose to put [client #6] in 'time out' and allowed him to sit facing the wall in his wheelchair for 40 minutes. He was also sitting the entire time in soiled (wet) pants. Staff was aware of this...Recommendations:			

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	Termination." -Investigation record dated 8/1/13 indicated: "Staff stated that she told [client #6] it was lunch time and he started whining and didn't want to come over to lunch area and kept whining. She told him to shut up and come over. She asked what she should have said instead. I told her she should allow him space and tell him when he was ready to let her know or come over. Verbal warning Discussion/training on how to encourage consumers and not using verbally abusive words/tone." -Investigation record dated 8/29/13 indicated: "Alleged Abuse/Neglect/Exploitation: Leaving consumer (client #6) in vehicle while going into store. Staff left [client #6] in car at [Store name] for approximately 3 minutes with the car running and locked to go to the bathroom. Staff receive a written warning for this incident." -Investigation record dated 9/24/13 indicated: "Names of alleged victims: [Client #1], [Client #2], [Client #3], [Client #4], [Client #5] and [Client #6]...Date/Time BDDS report filed: 9/24/13: September 22, 2013-overnight shift-[DSP #35] working with [DSP #36]. [DSP #26] stated that [DSP #35]			

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	slept on shift . [DSP #36] also stated that [DSP #35]'s tone is loud and abrupt to the consumers. [DSP #36] stated that in the last 2 weeks, [DSP #35] has slept on shift when she has worked with her and that is approximately 4 times in the last 2 weeks that she has worked with her...Summary of Incident: [DSP #35] has slept on shift. It is not determined how long she was asleep, but that is irrelevant. Sleeping on shift is prohibited. Two staff is scheduled on shift for care of consumers and line of sight protocol. Both staff and consumer identified an incident of staff [DSP #35] sleeping. It is found through the investigation [DSP #35]'s voice/tone is regularly described as loud and abrupt and direct...In addition to [DSP #35] disciplinary action-It is recommended that [DSP #36] receive a verbal warning for failing to immediately report any allegations of abuse, neglect, allegations." -Investigation record dated 10/28/13 indicated: "[DSP #19] was working with [DSP #17] on second shift. [DSP #19] went to office and sat in chair and fell asleep. [DSP #17] was working. All consumers were in bed. She thought [DSP #19] had gone outside for a break. [DSP #17] found her in the office asleep and tried to wake her. She could not.			

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	Third shift woke her. [DSP #19] admitted to falling asleep." Further review did not indicate what corrective action was put in place to prevent recurrence. A review of the facility's abuse and neglect policy dated 12/12 was conducted on 11/14/13 at 7:30 P.M.. Review of the policy indicated: "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			

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	places or potentially places a 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." An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 5:30 P.M.. The PC 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 PC indicated they were not. The PC indicated all incidents of abuse and neglect are to be immediately reported to the administrator and within 24 hours to BDDS. The PC indicated all incidents should be investigated and the results are to be reported to the administrator			

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	within 5 days. 9-3-2(a)			
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. Based on record review and interview, the facility failed for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), to report an injury of unknown origin and suspected abuse/neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.	W000153	In regard to ensuring the facility implemented its policy and procedures to protect the clients rights by preventing abuse/neglect/exploitation, The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director	01/10/2014

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	Findings include: A review of the facility's BDDS reports and investigation records was conducted on 11/12/13 at 11:15 A.M.. Review of the facility's investigation records indicated: -BDDS report dated 2/23/13...Date of Knowledge: 2/23/13...Submitted Date: 2/25/13 indicated: "Staff was going to give [client #6] a shower and staff noticed bruises on [client #6]'s left and right thigh. [Client #3] said he fell, he also said 'don't hurt me' when staff when (sic) to examine the bruises. Nothing violent was happening to warrant that statement . [Client #3] seemed like he didn't want to talk about it. He was looking down and his voice got quieter. Staff contacted Qualified Developmental Disabilities Professional (QDDP), QDDP contacted [Program Coordinator (PC)] and [Nurse]. QDDP had staff document everything for the rest of the weekend. The reason this is filed late is due to the fact that the QDDP and PC wanted to talk with [client #6] in person Monday morning to find out what happened. Per QDDP and PC conversation with [client #6] he stated that his mom was changing him after he peed on her couch. She was mad at him		were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. 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. 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	

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	and that is how he got the bruises...." -BDDS report dated 3/6/13...Date of Knowledge: 3/8/13...Submitted Date: 3/8/13 indicated: "Staff was lifting [client #6] into bed and [client #6] had a blister on his toe. When staff layed (sic) him down his blister was scraped off." The investigation record for this incident indicated: "QDDP was notified 2 days after blister was noticed. Nurse was notified that day....He was wearing his boots instead of tennis shoes. Caused toe to rub and blister....High risk (skin break down from wearing leg braces) states he is to wear tennis shoes with his braces." -Investigation record dated 9/24/13 indicated: "Names of alleged victims: [Client #1], [Client #2], [Client #3], [Client #4], [Client #5] and [Client #6]...Date/Time BDDS report filed: 9/24/13: September 22, 2013-overnight shift-[DSP #35] working with [DSP #36]. [DSP #26] stated that [DSP #35] slept on shift . [DSP #36] also stated that [DSP #35]'s tone is loud and abrupt to the consumers. [DSP #36] stated that in the last 2 weeks, [DSP #35] has slept on shift when she has worked with her and that is approximately 4 times in the last 2 weeks that she has worked with her...Summary of Incident: [DSP #35]		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 investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In 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.	

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	has slept on shift. It is not determined how long she was asleep, but that is irrelevant. Sleeping on shift is prohibited. Two staff is (sic) scheduled on shift for care of consumers and line of sight protocol. Both staff and consumer identified an incident of staff [DSP #35] sleeping. It is found through the investigation [DSP #35]'s voice/tone is regularly described as loud and abrupt and direct...In addition to [DSP #35] disciplinary action-It is recommended that [DSP #36] receive a verbal warning for failing to immediately report any allegations of abuse, neglect, allegations." An interview with the PC was conducted on 11/13/13 at 5:30 P.M.. The PC indicated these incidents were not immediately reported to the administrator or BDDS. The PC further indicated the incidents should have been immediately reported to the administrator and within 24 hours to BDDS. 9-3-2(a)			

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W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to report the results of 2 of 13 reviewed investigations, involving 1 of 3 sampled clients (client #1), to the administrator within five business days. Findings include: A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigation records was conducted on 11/12/13 at 11:15 A.M.. Review of the facility's investigation records indicated: -Investigation no (date noted) involving client #1 indicated: Statement from Nurse: "I received an incident report that two of [client #1]'s valium 2.5 mg (milligram) had been popped out due to a seal being broken and they were destroyed on Friday 6/21. [Staff #1] sent [Staff #2] over to look for the pills and they were not there. [Staff #1] and I (Nurse) went over on Tuesday 6/25 with	W000156	In regard to ensuring the facility implemented its policy and procedures to protect the clients rights by preventing abuse/neglect/exploitation, The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. 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. There is no opportunity for delay in an investigation	01/10/2014

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 12/11/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905	

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	[Staff #2] and the pills were not there. We requested per [Staff #4] to have [Direct Support Professional (DSP) #10] come into (sic) find the pills. She could not find the pills and was told to call [Staff #4]." Statement from Program Coordinator (PC) dated 6/27/13: "On Friday, June 21, 2013 following the staff meeting, [DSP #10] was doing Narc count in the kitchen. She brought to me a bubble pack of [client #1]'s Valium 2.5 mg (yellow half pills) and showed me that 2 of the seals were broken (looking on the back it was the right hand column-mid way down-not sure which 2 specific bubbles). I confirmed that they were broken. I told her to proceed with destroying them. I left the house as she went back into the kitchen to finish Narc count. I was not there when she finished the count/destruction. I worked at (sic) 12 hour shift on Saturday. I did not pass meds during that shift. Therefore I did not get into the med cabinets. I did not see any red bags or medications anywhere else in the house." Notes on investigation indicated: "7/1/13...Left message on her voicemail (DSP #10)...7/2/13: [DSP #10] called and left message...7/2/13: I explained that with her refusal to go for screening on Friday/Monday we had no choice but to assume it as positive and proceed with termination...." Further review of the		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 investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the	

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	record did not indicate the results of the investigation were reported to the administrator within 5 days. -Investigation dated 10/14/13 involving client #1 indicated: "Date Investigation begins: 10/14/13...Date Investigation completed: 10/23/13...Name of Alleged Victim: [Client #1]...Staff were getting ready to change [client #1]. [Staff #25] left the room to get pants out of the dryer for [client #1]. [Staff #25] knocked on door and [Staff #26] put bed rail up to answer the door. When she reached the door they heard a boom. [Client #1] had rolled and fallen off the bed...Small cut above the eye, hip pain...Staff left [client #1] to open door. She fell off changing table....Bed rail was checked by staff, bed rail gave out. New rail was bought and replaced immediately. Staff must be within arms length when changing." Further review of the record did not indicate the results of the investigation were reported to the administrator within 5 days. An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 5:30 P.M.. The PC indicated results from investigations are to be reported to the administrator within 5 days.		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.	

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	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 4 of 4 incidents of elopement for 1 of 3 sampled clients (client #3), the facility failed to take sufficient/effective corrective measures in regard to client #3's elopement. Findings include: A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigation records was conducted on 11/12/13 at 11:15 A.M.. Review of the facility's investigation records indicated: -Investigation dated 2/21/13 involving client #3 indicated: "Statement from DSP #13: I was discussing with [DSP #14] about when she wanted me to put on a change of clothes for [Client #5]. I was about to do that when I heard the alarm for the front door. [DSP #14] told	W000157	In response to W157, not taking sufficient/corrective measures in regard to clients elopement, Asi has implemented a debriefing and immediate IDT following any elopments. This will ensure that if plans were not followed, staff are immediately retrained and new procedures can be in place immediately if needed. The investigation completed after an elopement will contain corrective measures that are put in place and follow up will be done by the safety committee in weekly meetings. The Leadership team will review monthly all safety committee meeting notes to ensure measures are in place and being followed.	01/10/2014

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	me [client #3] had gone through the front door. [Staff name] asked me to go out to try to coax him back in. He was in [DSP #15]'s vehicle. I was able to walk him back into the building through the back door with [DSP #15]'s assistance....Statement from DSP #16: This writer had just completed changing [client #1]'s and others wet clothing in the washer machine, started the washer machine to going when [DSP #13] yelled '[client #3] went out the door." -Investigation dated 4/26/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Not following BSP line of sight...Summary of findings: Staff did not follow line of sight protocol....4/25/13-Incident-[Client #3]...Timeline: Elopement: At 5:24 P.M.-staff went to get [client #3] from his room for dinner. He was not there. [DSP #20] made an immediate call to [DSP #21], who was still in the area. [DSP #21] told her to call [PC]. [DSP #20] phoned [PC] as she was walking outside to look for [client #3]. She got in her car as [PC] told her he might be at the track since the high school track is right behind the group home and there was an event going on. She drove about 10 feet and saw him at the track. She saw [DSP #21] running in to the track field to get him. [DSP #21] got to him,			

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	15G736		12/11/2013

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	he was fine, just walking around the track. She assisted him to the group home. He was checked for any injuries. Nothing found." -Investigation dated 5/9/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Neglect-Elopement of consumer...Not following line of sight protocol...Summary of Findings: [Client #3] was to be in line of sight of [DSP #13] b/c (because) he was assigned to [DSP #13]'s group...[DSP #13] received disciplinary action. Statement from [DSP #30]: At approximately 2:30 on 5/8/13 [DSP #30] was in the office asking [DSP #31] a question and she heard the alarm sound. She looked out and staff all appeared busy and she did not see [client #3] anywhere. She went and looked out front and he was standing by [Staff name]'s jeep. Once she saw him out there, she yelled and went out after him. [DSP #31] ran out after [DSP #30]. Staff were able to get him back inside." -Investigation dated 6/3/13 involving client #3 indicated: "Alleged Abuse/Neglect/Exploitation: Neglect-Elopement of consumer. Not following line of sight protocol...Summary of findings: Staff			

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	did not follow line of sight protocol...Recommendations: All staff receive verbal warning due to schedules not passed. Staff were verbally told groups they have. PC and Assistant have been trained to give schedules....The morning of 6/3/13, [PC] was in front of my desk talking to me. Out of the corner of my eye I seen (sic) [client #3] walked pass (sic) the glass windows along the north side of the building. At that time [PC] saw [client #3] and said 'There [client #3], who is with him?' We realized that no one was with [client #3]. [PC] took out the front door and headed [client #3] off. I looked to the back door to see if it was open or if anyone was around. The door was shut and no (sic) was near the back door. I walked to the window to see if [PC] caught up with [client #3] and yell for staff if I needed to call for help. [PC] caught up with [client #3] by the front entrance. [Client #3] kept walking down the steps and was halted by [PC] at the bottom of the steps on the west side of the building (front parking lot). I walked around to help [PC] when [Staff name] went out the front door after [client #3]. I didn't go outside to help [PC] but started to go to let [DSP #35] know that [client #3] was outside. I told [DSP #36] that [PC] got him and I went back to the window to see if everything			

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	was alright. [PC] and [Staff name] were still with [client #3] at the bottom of the steps on the east side of the building. When staff headed out the front door to assist them with [client #3]. I return to work on my computer and continued working. After 5 to 8 minutes [client #3] strolled back into the facility followed by [PC]." A review of client #3's record was conducted on 11/13/13 at 2:44 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 #3] on a more restrictive Watchful Eye Protocol. [Client #3] should be in staff's LINE OF SIGHT AT ALL TIMES. The only exception to this is when [client #3] 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 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			

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	remains in place during sleeping hours as well. In addition, when [client #3] is in the backyard, staff should be outside with him to ensure that he has not left the area through the fence." An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 5:30 P.M.. The PC indicated facility staff should make sure client #3 is in line of sight at all times as per his BSP. When asked if the facility addressed the documented incidents, the PC indicated staff were retrained on his BSP. 9-3-2(a)			
W000218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 2 of 3 sampled clients and 2 additional clients (clients #1, #2, #5 and #6), the facility failed to obtain sensorimotor assessments.	W000218	In regard to W 218, ASI's comprehensive functional assessment has been updated to include sensorimotor development. All consumers have been assessed and if needed referred to a doctor for evaluation. As part of our annual	01/10/2014

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	Findings include: A morning observation was conducted at the group home on 11/12/13 from 5:20 P.M. until 7:00 P.M.. During the entire observation period clients #1, #5 and #6 utilized a wheelchair for mobility. Client #2 was observed to have an unsteady gait. An evening observation was conducted at the group home on 11/12/13 from 3:45 P.M. until 6:00 P.M.. During the entire observation period clients #1, #5 and #6 utilized a wheelchair for mobility. Client #2 was observed to have an unsteady gait. A review of client #1's record was reviewed on 11/13/13 at 5:15 P.M.. Review of the record did not indicate a sensorimotor assessment. A review of client #2's record was reviewed on 11/13/13 at 5:00 P.M.. Review of the record did not indicate a sensorimotor assessment. A review of client #5's record was reviewed on 11/13/13 at 4:30 P.M.. Review of the record did not indicate a sensorimotor assessment. A review of client #6's record was		evaluations, this will be included. Additionally, a review of all nursing services provided to each consumer has been completed and any missing information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as	

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	reviewed on 11/13/13 at 3:25 P.M.. Review of the record did not indicate a sensorimotor assessment. An interview with the Nurse was conducted on 11/13/13 at 5:30 P.M.. The Nurse indicated clients #1, #5 and #6 used a wheelchair for ambulation and client #2 had an unsteady gait. The Nurse indicated clients #1, #2, #5 and #6 did not have a sensorimotor assessment completed. 9-3-4(a)		Group Home staff meetings; each of which will take place monthly and will be documented.	
W000220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, record review and interview, the facility failed for 2 of 3 sampled clients and 1 additional client (clients #1, #2 and #4) to ensure a	W000220	In regard to W 220, ASI failed to ensure that all consumers received speech assessments. All consumers have now been scheduled to see	01/03/2014

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	speech assessment was completed for clients who need assistance with communication skills. Findings include: A morning observation was conducted at the group home on 11/12/13 from 6:30 A.M. until 9:00 A.M.. During the entire observation clients #1, #2 and #4 were non-verbal in communication in that the clients did not speak. An evening observation was conducted at the group home on 11/12/13 from 3:45 P.M. until 6:00 P.M.. During the entire observation clients #1, #2 and #4 were non-verbal in communication in that the clients did not speak. A review of client #1's record was conducted on 11/13/13 at 5:15 P.M.. Review of the record indicated client #1 was admitted to the facility on 6/1/07. Review of client #1's Individual Support Plan (ISP) dated 8/14/13 and/or record indicated she was non-verbal and did not indicate the client's speech and/or language skills had been assessed. A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. Review of the record indicated client #2 was admitted to the facility on 4/21/10.		their primary doctor to receive a referral for speech assessment. As part of our annual evaluations, this will be included. Additionally, a review of all nursing services provided to each consumer has been completed and any missing information/need is being completed. To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within	

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	Review of client #2's Individual Support Plan (ISP) dated 8/21/13 and/or record indicated she was non-verbal and did not indicate the client's speech and/or language skills had been assessed. A review of client #4's record was conducted on 11/13/13 at 4:00 P.M.. Review of the record indicated client #4 was admitted to the facility on 8/1/07. Review of client #4's Individual Support Plan (ISP) dated 9/20/13 and/or record indicated she required assistance with communication and did not indicate the client's speech and/or language skills had been assessed. An interview with the Nurse was conducted on 11/13/13 at 5:30 P.M.. The Nurse indicated there was no documentation to indicate clients #1, #2 and #4's speech and/or language skills had been assessed since they were admitted to the facility. 9-3-4(a)		this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented.	

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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. Based on record review and interview, the facility failed for 1 of 3 sampled clients and 2 additional clients (clients #3, #4 and #5), with documented resistance to participate in evacuation drills, non-compliance during medical appointments and to wear a bra, to include specific objectives in the Individual Service Plans (ISP) to address the clients' non-compliance. Findings include: 1. A review of the facility's records was conducted on 11/12/13 at 9:45 A.M.. Review of the group home evacuation drills dated 10/12 to 9/13 indicated: "-Emergency Drill Log...Location: [Group Home name]...Date: 12/30/2012...Time 6:00 A.M....Type of Drill: Fire...Problems that occurred: [Client #5] refused to participate. -Emergency Drill Log...Location: [Group Home name]...Date: 4/26/2013...Time 4:25 P.M....Type of Drill: Tornado...Problems that occurred:	W000227	In regard to W227, refusals by consumers are addressed in their behavior support plan when they meet the criteria for it to be in a bsp. Refusals for evacuation drills are addressed in evacuation procedures. There are individual procedures as needed. Refusal for dental appointments resulted in a referral for sedation dentistry. Refusal of client wearing a bra has been addressed with behavior specialist. All refusals are being addressed in specific ways, and will be documented. Refusals will be discussed in weekly IDT meetings to ensure that plans are in place to address refusals. All IDT notes will be reviewed at montly HRC meetings as follow up. HRC committee notes are reviewed monthly by Leadership team to ensure oversight of plans.	01/10/2014

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 12/11/2013
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	[Client #5] refused to participate. -Emergency Drill Log...Location: [Group Home name]...Date: 8/29/2013...Time 2:18 A.M....Type of Drill: Fire...Problems that occurred: Upon getting everyone out [client #5] refused to get up all consumers and staff was out in 5 minutes. Staff grab (sic) emergency blanket for [client #5] he was told we will use the emergency blanket for him he stated that he would fight us and he don't care if he die (sic) in a f---ing fire and leave him the f--- alone. In the event of a real fire staff would have had no choice but to use the emergency blanket." A review of client #5's record was conducted at the facility's administrative office on 11/13/13 at 4:30 P.M.. A review of client #5's Individual Support Plan (ISP) dated 8/28/13 did not indicate a training objective to address client #5's resistance during evacuation drills. An interview with the Program Coordinator (PC) was conducted at the facility's administrative office on 11/13/13 at 2:15 P.M.. When asked if client #5's ISP indicated client #5 had a training objective to address his refusals during evacuation drills, the PC indicated it did not.			

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	2. A morning observation was conducted at the group home on 11/12/13 from 6:30 A.M. until 9:00 A.M.. During the entire observation period client #4 did not wear a bra. Client #4 was not prompted by staff to wear a bra. An evening observation was conducted at the group home on 11/12/13 from 3:45 P.M. until 6:00 P.M.. During the entire observation period client #4 did not wear a bra. Client #4 was not prompted to wear a bra. A review of client #4's record was conducted on 11/13/13 at 4:00 P.M.. Client #4's ISP dated 9/20/13 did not include training objectives to address her non-compliance during medical appointments or to wear a bra. Client #4's most current dental evaluation dated 9/11/13 indicated "Unable to perform." Client #4's ISP dated 9/20/13 did not include a training objective to address refusals during appointments. 3. A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. Client #3's most current dental evaluation dated 9/11/13 indicated "Unable to perform." Client #3's ISP dated 8/22/13 did not include a training objective to address his non-compliance during medical appointments.			

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	An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 5:30 P.M.. When asked if clients #3 and #4's ISP addressed their non-compliance with appointments and/or treatments, the PC stated "No." The PC indicated client #4 will not wear a bra. When asked if client #4's ISP addressed her refusal to wear a bra, the PC stated "No." 9-3-4(a)			
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview, the facility failed to develop written instruction related to how 1 of 3 sampled clients and 2 additional clients (clients #1, #5 and #6), who required assistance with mobility and who used wheelchairs and walkers for mobility, were to be transferred in and out of their wheelchairs. Findings include:	W000240	In regard to W240, ASI failed to have written instructions for clients with mobility issues (walker, wheel chairs, assistance). Instructions are now in place and all clients needs have been reviewed. ASI's nurse is reviewing all COC's and completing all assessments needed according to schedule. A review of all nursing services provided to each consumer has been completed and any missing information/need is being	01/10/2014

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	A morning observation was conducted at the group home on 11/12/13 from 5:20 P.M. until 7:00 P.M.. During the entire observation period clients #1, #5 and #6 utilized a wheelchair for mobility. An evening observation was conducted at the group home on 11/12/13 from 3:45 P.M. until 6:00 P.M.. During the entire observation period clients #1, #5 and #6 utilized a wheelchair for mobility. At 4:00 P.M., Direct Support Professional (DSP) #5 was observed lifting client #1 from her wheelchair to a recliner in her bedroom using a Hoyer lift. A review of client #1's record was reviewed on 11/13/13 at 5:15 P.M.. Review of client #1's record did not indicate a protocol/guidelines on how to transfer client #1 in and out of her wheelchair. Review of her Individual Support Plan (ISP) dated 8/21/13 did not indicate how to transfer client #1 in and out of her wheelchair. A review of client #5's record was reviewed on 11/13/13 at 4:30 P.M.. Review of client #5's record did not indicate a protocol/guidance on how to transfer client #5 in and out of his wheelchair. Review of his ISP dated		completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented Quality Assurance monthly meetings will review schedule for consumers assessments to ensure they are	

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	8/28/13 did not indicate how to transfer client #5 in and out of his wheelchair. A review of client #6's record was reviewed on 11/13/13 at 3:25 P.M.. Review of client #6's record did not indicate a protocol/guidance on how to transfer client #6 in and out of his wheelchair. Review of his ISP dated 8/28/13 did not indicate how to transfer client #6 in and out of his wheelchair. An interview with the Nurse was conducted on 11/13/13 at 5:30 P.M.. When asked if there was a plan in place to give guidance when and how staff were to transfer clients #1, #5 and #6 in and out of their wheelchairs, the Nurse stated "No, there aren't plans in place." When asked if clients #1, #5 and #6's ISPs gave written instruction to staff for the use of a lift for client #1, the Nurse stated "No." 9-3-4(a)		being completed.	

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed at the group home. Findings include: A morning observation was conducted at the group home on 11/12/13 from 6:30 A.M. until 9:00 A.M.. During the entire observation period clients #4, #5 and #6 stayed in their bedrooms with no interaction and/or meaningful activity. Client #3 walked back and forth throughout the group home with no supervision. Clients #1 and #2 sat in the living room area with no meaningful activity. Direct Support Professionals (DSP) #1, #2 and #3 would walk into the rooms and occasionally check on clients #1, #2, #3, #4, #5 and #6, but did not offer any meaningful activity. At 7:45 A.M., DSP #2 began administering	W000249	In regard to W249,Each clients active treatment will be integrated, coordinated and monitored by the QIDP. The QIDP will review and/or revise the clients ISP annually or if there are changes to the clients goals based on quarterly progress reviews. Active Treatment Schedules will be updated annually and dated. In addition to QIDP oversight for active treatment, tracking for all active treatment schedules will be monitored weekly through individual chart audits. Any missing information in chart audits will be sent to QIDP and Director of Programming for follow up. All group home staff have been retrained on consumer specific plans to ensure compliance. In addition, the QIDP and Programming Coordinator are expected to be in the homes at least once per week to observe staff interactions with consumers. This will be an opportunity to retrain staff in the moment. These visits will be tracked using a Site Observation form. These will be reviewed by the Quality	01/10/2014

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	clients #1, #2, #3, #4 and #6's prescribed medications. DSP #2 popped out each of the clients' medications and fed them in yogurt to each client. No medication objectives were implemented during the medication administration period. An evening observation was conducted at the group home on 11/12/13 from 3:45 P.M. until 6:00 P.M.. From 4:50 P.M. until 5:55 P.M., clients #3 and #4 walked throughout the group home with no interaction and/or meaningful activity, with no supervision. Client #2 sat in her bedroom with no interaction and/or meaningful activity. Clients #1, #5 and #6 sat in the living and dining room area with no meaningful activity. DSP #3, #4 and #5 would walk into the rooms and occasionally check on clients #1, #2, #3, #4, #5 and #6, but did not offer any meaningful activity. A review of client #1's record was conducted on 11/13/13 at 5:15 P.M.. A review of client #1's Individual Support Plan (ISP) dated 8/21/13 indicated the following objectives that could have been implemented during both observations: "Will hold onto her cup and take a drink of Gatorade after taking her medication...Will stir a food item...Will participate in fine motor activities...Will identify a quarter, dime,		Assurance Committee at each meeting to identify areas for improvement and to ensure that changes that are made are maintained. ASI has set procedures for unnounced and announced site visites by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and Staffing. Each visit will have a site visitation form to be completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly.	

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	nickel and penny by sight...,Will participate in group exercise...Will be given a choice of two community outings." A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. The ISP dated 8/14/13 indicated the following objectives that could have been implemented during both observations: "Will put the vegetable or fruit in the food processor...Will stir a food item...Will help staff pop out pills into the medication cup...Will choose two individual activities to complete...Will do at least one fine motor skill activity." A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. The ISP dated 8/22/13 indicated the following objectives that could have been implemented during both observations: "Will pick the coins out of staff's hands that he needs to pay for a vending machine...Will put his pills in the applesauce after staff have handed him his pills...Will participate in a group activity...Will assist staff preparing one aspect of a meal." A review of client #4's record was conducted on 11/13/13 at 4:00 P.M.. The ISP dated 9/20/13 indicated the			

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	following objectives that could have been implemented during both observations: "Will measure out her Bene-fiber into a med cup...Will participate in a group exercise...Will complete one task with a peer...Will choose an activity." A review of client #5's record was conducted on 11/13/13 at 4:30 P.M.. The ISP dated 8/28/13 indicated the following objectives that could have been implemented during both observations: "Will identify his medications...Will understand the concept of money with three examples...Will write his brother's address...Will address the envelope to his brother for the letter he will help write...Will help write a one page letter to his brother with staff." A review of client #6's record was conducted on 11/13/13 at 3:25 P.M.. The ISP dated 8/28/13 indicated the following objectives that could have been implemented during both observations: "Will go shopping with the group home staff...Will pick out his clothes for the next day...Will understand the concept of money when given examples...Will be shown two of his medications when medications are being administered...Will engage in			

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	group activity...Will complete two individual activities on his own." An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 5:30 P.M.. The PC indicated facility staff should implement training objectives at all times of opportunity. 9-3-4(a)			
W000268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed for 1 additional client	W000268	In regard to W268, ASI failed to promote dignity of the consumer by not ensuring she wore a bra.	01/10/2014

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	(client #4), to promote her dignity by not ensuring she wore a bra. Findings include: A morning observation was conducted at the group home on 11/12/13 from 6:30 A.M. until 9:00 A.M.. During the entire observation period client #4 did not wear a bra. Client #4 was not prompted by staff to wear a bra. An evening observation was conducted at the group home on 11/12/13 from 3:45 P.M. until 6:00 P.M.. During the entire observation period client #4 did not wear a bra. Client #4 was not prompted to wear a bra. An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 5:30 P.M.. The PC indicated client #4 will not wear a bra and further indicated staff should prompt her to wear a bra. 9-3-5(a)		The issue of this consumer wearing a bra has been an on-going issue throughout her life. She has significant sensory issues. Behavior plans have addressed this issue in many ways with no success. The doctor has now written an order to not force her to wear a bra. ASI failed to show all supporting documents for this issue. Monthly checks of all paperwork and appropriate archiving of the information will allow ASI to produce information needed to show techniques used. Quality Assurance monthly meetings will provide follow up for this process to ensure all files are organized and contain needed information.	
W000318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.			

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	Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate nursing services for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6). Findings include: 1. Please refer to W331. The facility's nursing services failed to meet the nursing needs for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6). The facility's nursing services failed to ensure annual physicals and annual vision and hearing evaluations/assessments were completed. The facility's nursing services failed to conduct quarterly nursing assessments of each clients' health status and medical needs. The facility's nursing services failed to ensure clients had an annual dental evaluation and diagnosis. The facility's nursing services failed to ensure the pharmacist reviewed clients' medications on a quarterly basis. 2. Please refer to W322. The facility failed for 2 of 3 sampled clients and 1 additional client (clients #2, #3 and #4) to provide an annual physical.	W000318	In response to W318, review of all nursing services provided to each consumer has been completed and any missing information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each	01/10/2014

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	3. Please refer to W323. The facility failed for 2 of 3 sampled clients and 2 additional clients (clients #2, #3, #5 and #6) to have an annual vision and hearing evaluation/assessment. 4. Please refer to W336. The facility's nursing services failed for 3 of 3 sampled clients (clients #1, #2 and #3), to conduct quarterly nursing assessments of the clients' health status and medical needs. 5. Please refer to W352. The facility failed to assure 2 of 3 sampled clients and 1 additional client (clients #1, #3 and #4) had an annual dental evaluation and diagnosis. 6. Please refer to W362. The facility failed for 6 of 6 clients living at the group home, (clients #1, #2, #3, #4, #5 and #6) to ensure the pharmacist reviewed clients' medications on a quarterly basis. 9-3-6(a)		of which will take place monthly and will be documented	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 2 of 3 sampled clients and 1 additional client (clients #2, #3 and #4) to provide an annual physical. Findings include: A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. Client #2's record did not indicate when her last annual physical had been conducted. A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. Client #3's record did not indicate when his last annual physical had been conducted. A review of client #4's record was conducted on 11/13/13 at 4:00 P.M.. Client #4's record did not indicate when her last annual physical had been	W000322	In response to W322,a review of all nursing services provided to each consumer has been completed and any missing information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all	01/10/2014

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 12/11/2013
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905	

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	conducted. An interview with the Nurse was conducted on 11/13/13 at 11:45 A.M.. The Nurse indicated clients #2, #3 and #4 did not have an annual physical. 9-3-6(a)		pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented	
W000323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed for 2 of 3 sampled clients and 2 additional clients (clients #2, #3, #5 and #6) to have an annual vision and hearing evaluation/assessment. Findings include: A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. Client #2's record did not contain evidence she had an annual hearing evaluation/assessment. A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. Client #3's record did not contain	W000323	In response to W323,a review of all nursing services provided to each consumer has been completed and any missing information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the	01/10/2014

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	evidence he had an annual hearing evaluation/assessment. A review of client #5's record was conducted on 11/13/13 at 4:30 P.M.. Client #5's record indicated a most current annual physical dated 7/9/13 which did not indicate his hearing was evaluated/assessed. Client #5's record did not contain evidence his hearing had been assessed/evaluated. A review of client #6's record was conducted on 11/13/13 at 3:25 P.M.. Client #6's record indicated a most current annual physical dated 10/28/13 which did not indicate his hearing was evaluated/assessed. Client #6's record did not contain evidence his hearing been assessed/evaluated. An interview with the Nurse was conducted on 11/13/13 at 11:45 A.M.. The Nurse indicated there was no evidence of an annual evaluation/assessment of client #3, #4, #5 and #6's hearing. 9-3-6(a)		nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented	

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), the facility's nursing services failed to meet the nursing needs of the clients. The facility's nursing services failed to ensure annual physicals and annual vision and hearing evaluations/assessments were completed. The facility's nursing services failed to conduct quarterly nursing assessments of each clients' health status and medical needs. The facility's nursing services failed to ensure clients had an annual dental evaluation and diagnosis. The facility's nursing services failed to ensure the pharmacist reviewed clients' medications on a quarterly basis. Findings include: 1. A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. Client #2's record did not indicate when her last annual physical had been conducted. Client #2's record did not contain evidence she had an annual	W000331	In response to W331,a review of all nursing services provided to each consumer has been completed and any missing information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of	01/10/2014

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	hearing evaluation/assessment. A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. Client #3's record did not indicate when his last annual physical had been conducted. Client #3's record did not contain evidence he had an annual hearing evaluation/assessment. A review of client #4's record was conducted on 11/13/13 at 4:00 P.M.. Client #4's record did not indicate when her last annual physical had been conducted. A review of client #5's record was conducted on 11/13/13 at 4:30 P.M.. Client #5's record indicated a most current annual physical dated 7/9/13 which did not indicate his hearing was evaluated/assessed. Client #5's record did not contain evidence his hearing had been assessed/evaluated. A review of client #6's record was conducted on 11/13/13 at 3:25 P.M.. Client #6's record indicated a most current annual physical dated 10/28/13 which did not indicate his hearing was evaluated/assessed. Client #6's record did not contain evidence his hearing been assessed/evaluated.		Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented.	

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	An interview with the Nurse was conducted on 11/13/13 at 11:45 A.M.. The Nurse indicated there was no evidence of an annual evaluation/assessment of client #3, #4, #5 and #6's hearing. The Nurse further indicated clients #2, #3 and #4 did not have an annual physical. 2. A review of client #1's record was conducted on 11/13/13 at 5:15 P.M.. Client #1's record indicated no nursing quarterlies were completed. Client #1's most current annual physical was dated 9/18/13. Client #1's 8/11/13 Individual Support Plan (ISP) indicated client #1's diagnoses included, but were not limited to, general anxiety, nervous disorder, osteoporosis, cerebral palsy, general anxiety and bone disease. Client #1's 10/13 physician orders indicated client #2 received routine medications. A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. Client #2's record indicated no nursing quarterlies were completed. Client #2 did not have an annual physical completed. Client #2's 8/14/13 Individual Support Plan (ISP) indicated client #2's diagnoses included, but were not limited to, general anxiety, cerebral palsy, osteoporosis and seizure disorder. Client #2's 10/13 physician orders			

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	indicated client #2 received routine medications. A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. Client #3's record indicated "Nursing Quarterly" assessments on 9/20/12, 2/8/13, and 5/22/13. No Nursing Quarterly was available for review before 12/31/12, 3/31/13, 6/30/13 and 9/30/13. Client #3's did not have an annual physical in his record. Client #3's 8/22/13 Individual Support Plan (ISP) indicated client #3's diagnosis included, but was not limited to, Fragile X Syndrome. Client #3's 10/13 physician orders indicated client #3 received routine medications. An interview with the Nurse was conducted on 11/13/13 at 4:30 P.M.. The Nurse indicated nursing quarterlies are to be completed every three months. The Nurse further indicated the former nurse did not complete nursing quarterlies every three months. 3. A review of client #1's record was conducted at the facility's administrative office on 11/13/13 at 5:15 P.M.. Review of client #1's record indicated client #1 did not have an annual dental evaluation and diagnosis in her file. There was no indication when client #1 had a dental			

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	evaluation in her file. A review of client #3's record was conducted at the facility's administrative office on 11/13/13 at 2:44 P.M.. Review of client #3's record indicated: "Dental: 9/11/13: Unable to perform." Client #3 did not have an annual dental evaluation in his file. A review of client #4's record was conducted at the facility's administrative office on 11/13/13 at 4:00 P.M.. Review of client #4's record indicated: Dental 9/11/13: Unable to perform." Client #4 did not have an annual dental evaluation in her file. An interview with the Nurse was conducted at the facility's administrative office on 11/13/13 at 12:30 P.M.. The Nurse indicated clients #1, #3 and #4 did not have an annual dental exam in their record. The Nurse further indicated the clients were overdue for dental evaluations. 4. The pharmacist's medication review record was reviewed at the facility's administrative office on 11/13/13 at 3:53 P.M.. Review of the pharmacist's medication review record indicated no medication reviews for clients #1, #2, #3, #4, #5 and #6.			

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	An interview with the nurse was conducted at the facility's administrative office on 11/13/13 at 4:00 P.M.. The nurse indicated there were no medication reviews submitted by the pharmacy for the last quarter of 2012, the first, second and third quarter of 2013. When asked how often medications are to be reviewed by the pharmacist, the nurse stated "They should be reviewed quarterly." 9-3-6(a)			
W000336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3), the facility's nursing services failed to conduct quarterly nursing assessments of each client's health status and medical needs. Findings include:	W000336	In response to W336,a review of all nursing services provided to each consumer has been completed and any missing information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly	01/10/2014

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	A review of client #1's record was conducted on 11/13/13 at 5:15 P.M.. Client #1's record indicated no nursing quarterlies were completed. Client #1's most current annual physical was dated 9/18/13. Client #1's 8/11/13 Individual Support Plan (ISP) indicated client #1's diagnoses included, but were not limited to, general anxiety, nervous disorder, osteoporosis, cerebral palsy, general anxiety and bone disease. Client #1's 10/13 physician orders indicated client #1 received routine medications. A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. Client #2's record indicated no nursing quarterlies were completed. Client #2 did not have an annual physical completed. Client #2's 8/14/13 Individual Support Plan (ISP) indicated client #2's diagnoses included, but were not limited to, general anxiety, cerebral palsy, osteoporosis and seizure disorder. Client #2's 10/13 physician orders indicated client #2 received routine medications. A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. Client #3's record indicated "Nursing Quarterly" assessments on 9/20/12, 2/8/13, and 5/22/13. No Nursing		chart audit process. This will ensure that all medical appointments, documentation and follow-ups are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented.	

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	Quarterly was available for review for 8/13. Client #3's did not have an annual physical in his record. Client #3's 8/22/13 Individual Support Plan (ISP) indicated client #3's diagnosis included, but was not limited to, Fragile X Syndrome. Client #3's 10/13 physician orders indicated client #3 received routine medications. An interview with the Nurse was conducted on 11/13/13 at 4:30 P.M.. The Nurse indicated nursing quarterlies are to be completed every three months. The Nurse further indicated the former nurse did not complete nursing quarterlies every three months. 9-3-6(a)			
W000352	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, the facility failed to assure 2 of 3 sampled clients and 1 additional client	W000352	In response to W352,a review of all nursing services provided to each consumer has been completed and any missing	01/10/2014

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	(clients #1, #3 and #4) had an annual dental evaluation. Findings include: A review of client #1's record was conducted at the facility's administrative office on 11/13/13 at 5:15 P.M.. Review of client #1's record indicated client #1 did not have an annual dental evaluation in her file. There was no indication when client #1 had a dental evaluation in her file. A review of client #3's record was conducted at the facility's administrative office on 11/13/13 at 2:44 P.M.. Review of client #3's record indicated: "Dental: 9/11/13: Unable to perform." Client #3 did not have an annual dental evaluation in his file. A review of client #4's record was conducted at the facility's administrative office on 11/13/13 at 4:00 P.M.. Review of client #4's record indicated: Dental 9/11/13: Unable to perform." Client #4 did not have an annual dental evaluation in her file. An interview with the Nurse was conducted at the facility's administrative office on 11/13/13 at 12:30 P.M.. The Nurse indicated clients #1, #3 and #4 did		information/need is being completed To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups are in place. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented.	

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	not have an annual dental exam in their record. The Nurse further indicated the clients were overdue for dental evaluations. 9-3-6(a)			
W000362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed for 6 of 6 clients living at the group home, (clients #1, #2, #3, #4, #5 and #6) to ensure the pharmacist reviewed clients' medications on a quarterly basis. Findings include: The pharmacist's medication review record was reviewed at the facility's administrative office on 11/13/13 at 3:53 P.M.. Review of the pharmacist's medication review record indicated no medication reviews for clients #1, #2, #3, #4, #5 and #6. A review of client #1's record was conducted on 11/13/13 at 5:15 P.M..	W000362	In regard to W362, ASI failed to ensure quarterly pharmacy reviews were performed for clients, pharmacy reviews the last two quarters were sent to the agency nurse to review. The nurse that was on staff the last two quarters has resigned. Reviews were unable to be located. To ensure this does not happen in the future, ASI has contacted pharmacy to send the reviews to multiple management staff. The reviews from last year have been obtained. Upon each quarterly review, the nurse will create an action plan and present to the PD. Safety committee, which meets weekly, will also review and the IDT to ensure that the deficiencies are corrected.	01/10/2014

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	The record indicated client #1 was prescribed medications. A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. The record indicated client #2 was prescribed medications. A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. The record indicated client #3 was prescribed medications A review of client #4's record was conducted on 11/13/13 at 4:00 P.M.. The record indicated client #4 was prescribed medications A review of client #5's record was conducted on 11/13/13 at 4:30 P.M.. The record indicated client #5 was prescribed medications. A review of client #6's record was conducted on 11/13/13 at 3:25 P.M.. The record indicated client #6 was prescribed medications. An interview with the nurse was conducted at the facility's administrative office on 11/13/13 at 4:00 P.M.. The nurse indicated there were no medication reviews submitted by the pharmacy for the last quarter of 2012,			

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	the first, second and third quarter of 2013. When asked how often medications are to be reviewed by the pharmacist, the nurse stated "They should be reviewed quarterly." No further documentation was available for review to indicate medications were reviewed by the pharmacist. 9-3-6(a)			
W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview, the facility failed for 1 of 5 clients observed during the morning medication administration (client #2) to ensure staff administered the client's medications, as ordered without error. Findings include: A morning observation was conducted at the group home on 11/12/13 from 6:30	W000369	In regard to W369, ASI failed to administer the clients medication as ordered, ASI group home staff have been retrained by the agency nurse on medication orders. To ensure continued compliance, agency nurse will do a once a week random medication pass review. The agency also pulls random staff for a med pass evaluation once a month. To ensure continued training, staff will be review	01/10/2014

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	A.M. until 9:00 A.M.. At 8:30 A.M., Direct Support Professional (DSP) #4 administered client #2's prescribed oral medications with yogurt. DSP #4 administered client #2's "Omeprazole 20 mg capsule." Review of the medication packet label and the Medication Administration Record (MAR) dated 11/2013 was done at 8:35 A.M. and indicated "Crush Meds...Omeprazole 20 mg capsule...1 capsule daily before a meal." Client #2 ate breakfast at 7:20 A.M.. Client #2 did not take her medication before her meal and client #2's medications were not crushed. An interview with the Nurse was conducted at the facility's administrative office on 11/13/13 at 4:20 P.M.. The Nurse indicated DSP #4 should have administered the client's medications as ordered. The Nurse further indicated staff should have followed the directions on the label. 9-3-6(a)		medication orders in the monthly staff meetings. Safety committee will review staff meeting agenda and provide follow up to ensure trainings are being completed. Safety committee will review weekly.	

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W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on record review and interview, the facility failed to assure the repair of adaptive equipment for 1 of 3 clients (client #6) who used a wheelchair for mobility. Findings include: A morning observation was conducted at the group on 11/12/13 from 6:30 A.M. until 9:00 A.M.. During the entire observation client #6 sat in a standard wheelchair. At 7:00 A.M., client #6 asked Direct Support Professional (DSP) #2 "When am I getting my wheelchair fixed? I need my wheelchair." An evening observation was conducted at the group on 11/12/13 from 3:45 P.M. until 6:00 P.M.. During the entire observation client #6 sat in a standard wheelchair. At 4:10 P.M., client #6 asked this surveyor "Can you get my wheelchair? I need my wheelchair." This surveyor asked client #6 where his wheelchair was. Client #6 stated "Look in the garage." At 4:15 P.M., client #6's	W000436	IN response to W 436, Adaptive equipment checklists specific to each client are being completed. All equipment has been checked. The current adaptive equipment checklists were completed weekly by staff and turned in to the receptionist to scan to Nurse and PC. The system did not work because different staff were responsible all of the time. The new system requires the Nurse to check all equipment weekly and turned in to Programming Coordinator to review for any repairs needed. Nurse will schedule repairs. All adaptive equipment checklists are presented to Safety Committee bi-monthly to review. The Director of Programming is the safety committee chairperson and oversees the coordinators. A master list of all appointments needed including annual wheelchair evaluations will be maintained by the nursing assistant with oversight from the nurse. All appointments scheduled will be put in a master calendar with alerts sent to all relevant staffs calendar. Alerts for appointments are received on the	01/10/2014

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	personalized wheelchair was observed in the corner of the garage. When asked what was wrong with his wheelchair, client #6 stated "It's broken. My wheel is broken." When asked how long it had been broken, he stated "A long time." A review of client #6's record was conducted on 11/13/13 at 5:30 P.M.. Review of client #6's record indicated he used a wheelchair at all times for mobility. The record failed to indicate client #6's wheelchair had repairs completed to his wheelchair. An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 2:15 P.M.. The PC indicated client #6's wheelchair needed the wheel fixed. When asked when the wheelchair would be repaired, the PC indicated she did not know. 9-3-7(a)		smart phones carried by all Coordinators, QIDP's and Nurse. .	
W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the morning shift (8:00	W000440	In response to W440, ASI failed to ensure all required evacuation drills were completed, ASI has identified that staff are not	01/10/2014

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	A.M. to 4:00 P.M.) during the second quarter (April 1st through June 30th) and third quarter (July 1st through September 30th) of 2013 which affected 6 of 6 clients living in the facility (clients #1, #2, #3, #4, #5 and #6.) Findings include: The facility's records were reviewed on 11/12/13 at 9:45 A.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5 and #6 on the evening during the second and third quarters of 2013. The Program Coordinator (PC) was interviewed on 11/13/13 at 2:15 P.M.. The PC indicated evacuation drills are to be conducted during each quarter for each shift. 9-3-7(a)		following the schedule.Coordinators are responsible for scheduling contacting staff and tracking fire drills. Coordinators will call to remind staff of drill to be performed on shift. A yearly calendar is in place so that staff know what days and times drills are to be performed. All completed drills are brought to safety bi-monthly meeting for review. Director of Programming is responsible for supervision of Coordinator as safety committee chair person. Tracking for all drills is kept for safety committee. The Safety Committee will monitor at it's monthly meetings.	
W000448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview, the facility failed to investigate problems with evacuation drills. This potentially affected 1 of 6 clients (client #5) who reside at the residence.	W000448	In response to W448, ASI failed to investigate all problems with evacuation drills, it was determined that staff needed retrained on completing thorough paperwork to help safety committee evaluate emergency	01/10/2014

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	Findings include: A review of the facility's records was conducted on 11/12/13 at 9:45 A.M.. Review of the group home evacuation drills dated 10/12 to 9/13 indicated: "-Emergency Drill Log...Location: [Group Home name]...Date: 12/30/2012...Time 6:00 A.M....Type of Drill: Fire...Problems that occurred: [Client #5] refused to participate. -Emergency Drill Log...Location: [Group Home name]...Date: 4/26/2013...Time 4:25 P.M....Type of Drill: Tornado...Problems that occurred: [Client #5] refused to participate. -Emergency Drill Log...Location: [Group Home name]...Date: 8/29/2013...Time 2:18 A.M....Type of Drill: Fire...Problems that occurred: Upon getting everyone out [client #5] refused to get up all consumers and staff was out in 5 minutes. Staff grab (sic) emergency blanket for [client #5] he was told we will use the emergency blanket for him he stated that he would fight us and he don't care if he die (sic) in a f---ing fire and leave him the f--- alone. In the event of a real fire staff would have had no choice but to use the emergency		drills to determine any needs/ action plans for the the process. Upon completion of drills, the paperwork will be scanned to the PC to evaulate and summarize for weekly safety meeting. Assistant PC's will also be tracking drills to ensure the drills are evaulated at the safety meeting. Safety meeting minutes will be reviewed by Leadership to ensure follow up for any plans put in place as a result of the review.	

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	blanket." An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 2:15 P.M.. When asked if there was any documentation to indicate the facility conducted investigations in regards to the documented problems that occurred during the evacuation drills, the PC stated "No." When asked if the facility should have conducted investigations in regards to the documented problems encountered, the PC stated "Yes they should have." 9-3-7(a)			
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 3 sampled clients (client #2), the facility failed to assure the staff provided food in accordance with the client's diet order. Findings include:	W000460	In regard to W460, ASI failed to provide food in accordance with the clients diet order. Staff have been retrained on the consumers diet orders at the group home. ASI Nurse is responsible for training staff and all trainings are monitored by our records admin assistant. Any staff not attending needed and required	01/10/2014

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	A morning observation was conducted at the group on 11/12/13 from 6:30 A.M. until 9:00 A.M.. At 7:20 A.M., DSP #1 placed client #2's already prepared plate on the dining table and poured her juice and milk into each cup. DSP #1 then went around the table with a knife and cut client #2's pancakes and ham into bite size pieces. At 7:30 A.M., client #2 ate her breakfast. Client #2's meal was not of a mechanical soft consistency with ground meats. A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. Review of client #2's most current Nutritional Assessment dated 10/18/13 indicated: "Mechanical soft and ground meats." An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 2:15 P.M.. The PC indicated staff should have followed the client's prescribed diet. 9-3-8(a)		trainings are taken off shift until they have completed trainings. In addition, the QIDP and Programming Coordinator are expected to be in the homes at least once per week to observe staff interactions with consumers. This will be an opportunity to retrain staff in the moment. These visits will be tracked using a Site Observation form. These will be reviewed by the Quality Assurance Committee at each meeting to identify areas for improvement and to ensure that changes that are made are maintained. ASI has set procedures for unnounced and announced site visites by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and Staffing. Each visit will have a site visitation form to be completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly.	

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W000484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) residing in the group home to provide butter knives and butter/margarine at the dining table. Findings include: A morning observation was conducted at the group on 11/12/13 from 6:30 A.M. until 9:00 A.M.. At 7:20 A.M., DSP #1 placed the already prepared plates on the dining table and poured the clients juice and milk into each cup. DSP #1 then went around the table with a knife and cut the clients' pancakes and ham into bite size pieces. DSP #1 stated to DSP #2 "[client #6] is going to be upset, there is no butter for his pancakes, you know he only likes butter on his pancakes." DSP #2 then stated "Yes, he's not going to like that." At 7:30 A.M., clients #1, #2, #3, #4, #5 and #6 were prompted to the table to eat their breakfast. Client #6 asked "Where is the butter? I want butter." DSP #1 stated "We don't have any butter, do you want syrup?" Client #6 shook his head indicating no and stated "I want butter." At 7:35 A.M.,	W000484	In response to W484, the facility failed to provide a full set of silverware for clients at meal time, and all condiments, ASI has implemented weekly site visitations (announced and unannounced) to observe many different times that staff work with consumers in the home. These visitations are done by PC, QIDP, Nurse, Assistant Coordinator and Med Assistant. Site visitation forms are completed on each visit and sent immediately to the PD and Administrative Director for review. Any issues needing immediate attention require a phone call to a Director. All site visitations are reviewed in Quality Assurance monthly. All staff have been re-trained on meal time procedures. Review of training topics take place monthly at staff meetings to ensure all staff are reminded of procedures. Weekly site visits include a minimum of 3 visits a week to each group home site.	01/10/2014

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	client #3 refused to eat his prepared plate of food, walked to the counter put 2 slices of bread in the toaster and went into the refrigerator. DSP #1 stated "There isn't any butter [client #3]." Client #3 looked at DSP #1 and she again stated "There isn't any more butter someone will have to pick some up when they go shopping today." Client #3 walked out of the kitchen and refused to eat. No butter knives and butter/margarine were observed on the table for clients #1, #2, #3, #4, #5 and #6's use. An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 2:15 P.M.. The PC indicated butter knives and butter/margarine should be put on the table for the clients to use. 9-3-8(a)			
W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review and interview, the facility failed to assure 6	W000488	In response to W488, the facility failed to ensure that clients	01/10/2014

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	of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6) were involved in meal preparation and served themselves at meal times as independently as possible. Findings include: A morning observation was conducted at the group on 11/12/13 from 6:30 A.M. until 9:00 A.M.. From 6:30 A.M. until 7:20 A.M., client #2 sat in the living room with no interaction and no activity. Client #1 sat in the kitchen with no interaction and no activity. Client #3 walked around the group home with no interaction or activity. Direct Support Professional #1 (DSP) cooked and served the clients' meal which consisted of pancakes, sliced ham, milk and juice. At 7:20 A.M., DSP #1 placed the already prepared plates on the dining table and poured the clients juice and milk into each cup. At 7:30 A.M., clients #1, #2, #3, #4, #5 and #6 were prompted to the table to eat their breakfast. Clients #1, #2, #3, #4, #5 and #6 did not assist in preparing their meal and did not serve themselves. An evening observation was conducted at the group on 11/12/13 from 3:45 P.M. until 6:00 P.M.. At 5:45 P.M., clients #1, #2, #3, #4, #5 and #6 sat at the		prepared their food as independently as possible. ASI has implemented weekly site visitations (announced and unannounced) to observe many different times that staff work with consumers in the home. Meal times are one of the topics. These visitations are done by PC, QIDP, Nurse, Assistant Coordinator and Med Assistant. Site visitation forms are completed on each visit and sent immediately to the PD and Administrative Director for review. Any issues needing immediate attention require a phone call to a Director. All site visitations are reviewed in Quality Assurance monthly. All staff have been re-trained on consumer dining plans. Review of training topics take place monthly at staff meetings to ensure all staff are reminded of procedures and plans. Weekly site visits include a minimum of 3 visits a week to each group home site.	

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	dining table while DSPs #3, #4 and #5 served their dinner which consisted of chicken salad, Spanish rice, refried beans, bread sticks, milk and water. Clients #1, #2, #3, #4, #5 and #6 did not serve themselves. A review of client #1's record was conducted on 11/13/13 at 5:15 P.M.. A review of client #1's Individual Support Plan (ISP) dated 8/21/13 indicated: "Will stir a food item." A review of client #2's record was conducted on 11/13/13 at 5:00 P.M.. The ISP dated 8/14/13 indicated: "Will put the vegetable or fruit in the food processor...Will stir a food item." A review of client #3's record was conducted on 11/13/13 at 2:44 P.M.. The ISP dated 8/22/13 indicated: "Will assist staff preparing one aspect of a meal." An interview with the Program Coordinator (PC) was conducted on 11/13/13 at 2:15 PM. The PC indicated the clients could assist in meal preparation and in serving themselves with staff assistance. 9-3-8(a)			

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