

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 01/24/2014
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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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W000000	<p>This visit was for a post certification revisit to a full recertification and state licensure survey completed on December 11, 2013.</p> <p>Date of Survey: January 24, 2014.</p> <p>Facility number: 005592 Provider number: 15G736 AIM number: 200859130</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/30/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on record review and interview for 2 of 3 sampled clients and 2 additional clients (clients #2, #3, #5 and #6), the facility failed to obtain sensorimotor assessments.</p>	W000218	In regard to W 218, ASI's comprehensive functional assessment has been updated to include sensorimotor development. All consumers have been assessed and are following recommendations.. As part of our annual evaluations,	02/23/2014

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>A review of client #2's record was conducted on 1/24/14 at 3:00 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #3's record was conducted on 1/24/14 at 2:00 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #5's record was conducted on 1/24/14 at 2:30 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #6's record was conducted on 1/24/14 at 12:30 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>An interview with the Nurse was conducted on 1/24/14 at 3:40 P.M.. The Nurse indicated clients #3, #5 and #6 used a wheelchair for ambulation and client #2 had an unsteady gait. The Nurse indicated clients #2, #3, #5 and #6 did not have a sensorimotor assessment completed.</p> <p>This deficiency was cited on 12/11/13. The facility failed to implement a systemic plan of correction to prevent</p>		<p>this will be included. Additionally, a review of all nursing services provided to each consumer has been completed and any missing information/need is complete To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse have implemented a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. The nurse has implemented new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits are also completed on tracking sheets. All staff who work with these consumers are trained and the nurse has implemented in-service trainings at monthly staff meetings. All of these systemic changes are 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 occurs 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 occurs in individual supervision as well as Group Home staff meetings; each</p>		

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W000220	<p>recurrence.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sampled clients and 1 additional client (clients #1, #2 and #6) to ensure a speech assessment was completed for clients who need assistance with communication skills.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/24/14 from 5:15 P.M. until 6:15 P.M.. During the entire observation clients #1, #2 and #6 were non-verbal in communication in that the clients did not speak.</p> <p>A review of client #1's record was conducted on 1/24/14 at 1:30 P.M.. Review of the record indicated client #1 was admitted to the facility on 8/1/07.</p>	W000220	<p>of which take place monthly and is documented.</p> <p>In regard to W 220, ASI failed to ensure that all consumers received speech assessments. All consumers have now seen their primary doctor to receive a referral for speech assessment. As part of our annual evaluations, this is 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 implemented a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. The nurse implemented new nursing protocols to ensure assessments and tracking of needed</p>	02/23/2014			

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	<p>Review of client #1'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.</p> <p>A review of client #2's record was conducted on 1/24/14 at 3:00 P.M.. Review of the record indicated client #2 was admitted to the facility on 4/21/10. 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.</p> <p>A review of client #6's record was conducted on 1/24/14 at 12:30 P.M.. Review of the record indicated client #6 was admitted to the facility on 6/1/07. Review of client #6'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.</p> <p>An interview with the Nurse was conducted on 1/24/14 at 3:40 P.M.. The Nurse indicated there was no documentation to indicate clients #1, #2 and #6's speech and/or language skills had been assessed since they were admitted to the facility.</p>		<p>information based on assessments is completed. Weekly chart audits are completed on tracking sheets. All staff who work with these consumers are trained and the nurse has implemented 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.</p>				

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W000227	<p>This deficiency was cited on 12/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>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 1 additional client (clients #1 and #4), with documented 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.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/24/14 from 5:15 P.M. until 6:15 P.M.. During the entire observation period client #1 did not</p>	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	02/23/2014

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	<p>wear a bra. Client #1 was not prompted to wear a bra.</p> <p>A review of client #1's record was conducted on 1/24/14 at 4:00 P.M.. Client #1's dental evaluation dated 9/11/13 indicated "Unable to perform." Client #1's ISP dated 9/20/13 did not include training objectives to address her non-compliance during medical appointments or to wear a bra.</p> <p>A review of client #4's record was conducted on 1/24/14 at 2:44 P.M.. Client #4's dental evaluation dated 9/11/13 indicated "Unable to perform." Client #4's ISP dated 8/22/13 did not include a training objective to address his non-compliance during medical appointments.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/24/14 at 4:45 P.M.. When asked if clients #1 and #4's ISPs addressed their non-compliance with appointments and/or treatments, the QIDP stated "No." The QIDP indicated client #1 will not wear a bra. When asked if client #1's ISP addressed her refusal to wear a bra, the QIDP stated "No."</p> <p>This deficiency was cited on 12/11/13.</p>		<p>monthly HRC meetings as follow up. HRC committee notes are reviewed monthly by Leadership team to ensure oversight of plans.</p>				

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W000240	<p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 sampled clients and 2 additional clients (clients #3, #5 and #6), the facility failed to ensure the clients' Individual Support Plans (ISPs) contained guidelines for staff to follow during transfers in and out of wheelchairs.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 1/24/14 at 2:00 P.M.. Review of client #3's record did not indicate a protocol/guidance on how to transfer client #3 in and out of his wheelchair. Review of his ISP dated 8/28/13 did not indicate how to transfer client #3 in and out of his wheelchair.</p> <p>A review of client #5's record was</p>	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 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	02/23/2014			

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	<p>conducted on 1/24/14 at 2:30 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 8/28/13 did not indicate how to transfer client #5 in and out of his wheelchair.</p> <p>A review of client #6's record was conducted on 1/24/14 at 12:30 P.M.. Review of client #6's record did not indicate a protocol/guidelines on how to transfer client #6 in and out of her wheelchair. Review of her Individual Support Plan (ISP) dated 8/21/13 did not indicate how to transfer client #6 in and out of her wheelchair.</p> <p>An interview with the Nurse was conducted on 1/24/14 at 3:40 P.M.. When asked if there was a plan in place to give guidance when and how staff were to transfer clients #3, #5 and #6 in and out of their wheelchairs, the Nurse stated "No, there aren't plans in place." When asked if clients #3, #5 and #6's ISPs gave written instruction to staff for the use of a lift for client #3, the Nurse stated "No."</p> <p>This deficiency was cited on 12/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		<p>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 being completed.</p>		

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W000268	<p>9-3-4(a)</p> <p>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 of 3 sampled clients (client #1), to promote her dignity by not ensuring she wore a bra.</p> <p>Findings include:</p> <p>A facility owned day program observation was conducted on 1/24/14 from 11:45 A.M. until 12:15 P.M.. During the entire observation period client #1 did not wear a bra. Client #1 was not prompted by staff to wear a bra.</p> <p>An evening observation was conducted at the group home on 1/24/14 from 5:15 P.M. until 6:20 P.M.. During the entire observation period client #1 did not wear a bra. Client #1 was not prompted to wear a bra.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/24/14 at</p>	W000268	In regard to W268, ASI failed to promote dignity of the consumer by not ensuring she wore a bra. 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. However, consumer has a goal and social story to continue to encourage her to wear a bra. . 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.	02/23/2014			

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W000323	<p>5:30 P.M.. The QIDP indicated client #1 will not wear a bra.</p> <p>This deficiency was cited on 12/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients and 2 additional clients (clients #2, #3, #4 and #5) to provide an annual hearing evaluation/assessment.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 1/24/14 at 3:00 P.M.. Client #2's record did not contain evidence she had an annual hearing evaluation/assessment.</p> <p>A review of client #3's record was</p>	W000323	In response to W323,a review of all nursing services provided to each consumer has been completed and any missing information/need is complete 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.	02/23/2014			

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	<p>conducted on 1/24/14 at 2:00 P.M.. Client #3's record indicated a most current annual physical dated 10/28/13 which did not indicate his hearing was evaluated/assessed. Client #3's record did not contain evidence his hearing been assessed/evaluated.</p> <p>A review of client #4's record was conducted on 1/24/14 at 1:00 P.M.. Client #4's record did not contain evidence he had an annual hearing evaluation/assessment.</p> <p>A review of client #5's record was conducted on 1/24/14 at 2:30 P.M.. Client #5's record did not contain evidence his hearing had been assessed/evaluated.</p> <p>An interview with the Nurse was conducted on 1/24/14 at 3:40 P.M.. The Nurse indicated there was no evidence of an annual evaluation/assessment of client #2, #3, #4 and #5's hearing.</p> <p>This deficiency was cited on 12/11/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>		<p>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</p>		

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 3 sampled clients and 3 additional clients (clients #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 hearing evaluations/assessments were completed. The facility's nursing services failed to obtain sensorimotor assessments.</p> <p>Findings include:</p> <p>Please refer to W218: The facility failed for 2 of 3 sampled clients and 2 additional clients (clients #2, #3, #5 and #6), to obtain sensorimotor assessments.</p> <p>Please refer to W323: The facility failed for 2 of 3 sampled clients and 2 additional clients (clients #2, #3, #4 and #5) to provide an annual hearing evaluation/assessment.</p> <p>This deficiency was cited on 12/11/13. The facility failed to implement a systemic plan of correction to prevent</p>	W000331	<p>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</p>	02/23/2014			

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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	
	recurrence. 9-3-6(a)		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.		