

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  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for the investigation of complaint #IN00157853.</p> <p>COMPLAINT #IN00157853: Substantiated. Federal/State deficiencies related to the allegation(s) were cited at W149, W153, W154, W189, W368 and W436.</p> <p>Dates of Survey: October 27, 28, 29 and November 3 and 7, 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 11/19/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p>			

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Based on record review and interview for 3 of 3 sampled clients and 3 additional clients (clients A, B, C, D, E and F), the facility neglected to implement written policy and procedures to prevent alleged abuse/neglect in regard to 1. supervision of clients, 2. alleged physical and verbal abuse by staff, 3. conducting thorough investigations and implementing client C's watchful eye protocol.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 10/28/14 at 12:30 P.M.. Review of the records indicated:</p> <p>1. -Investigation dated 5/19/14 involving clients D and F indicated: "It was reported that [Client D] had red Mark's (sic) on his back the evening of 5/19/14. The red marks were suspicious in nature. The agency nurse asked [client D] how he got the red marks on his back and he stated that [Staff #17] hit him. During investigation of the injury, [Staff #17] was accused of verbally abusing [client F] by multiple staff. The allegation that [client F] was verbally abused by [Staff #17] was not reported on 5/18/14. The allegation of verbal abuse was</p>	W000149	<p>In response to W149, the facility neglected to implement written policy and procedures to prevent alleged abuse/neglect in regard to 1.supervision of clients, 2. alleged physical and verbal abuse by staff, 3. conducting thorough investigations and implementing client C's watchfuleye protocol. All staff has been retrained on watchful eye protocol, and supervision of clients especially related to consumer to consumer aggression. In response to investigations, any time an Incident Report is written,the DSP must call the Programming Coordinator, QIDP, and Nurse to report theincident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. The IR's are sent to the PD at the same time they are scanned to the others and the PD is notified by text of all IR's. The safety committee is following up weekly on any BDDS reportable injuries. All IR's that require investigation are noted by PD assistant and marked to be reviewed in 5 days to ensure all investigations are completed. Director of Administration will also review all investigations. Additionally, as a part of our state recertification process we are</p>	12/01/2014

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  11/07/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>investigated with the physical abuse....Investigation for verbal abuse by [Staff #17]-abuse was substantiated. Multiple witnesses. There was also an allegation of physical abuse that could not be substantiated but seemed likely to have occurred based on time frame and reporting. Termination was recommended and happened on May 23rd. Multiple accusations of stealing food from the company. Witness of her eating food on each shift. Had already received disciplinary action for sleeping."</p> <p>-Investigation dated 7/27/14 involving clients A, B, C, D, E and F indicated: "Describe any injuries or right violations that are alleged: Neglect...On 7/27/14 upon arriving to work at 8:50 A.M., [Staff #13] stated that she could not get anyone to answer the door and when [Staff #14] and [Staff #15] did finally answer the door, it was apparent that they had been asleep. Meds were not passed, consumers were still in bed....Summary of Findings: [Staff #14 and #15] had to have been sleeping. [Staff #15] admits to it, [Staff #14] does not....Conclusion: Substantiated. Staff received disciplinary action."</p> <p>2. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR)</p>		<p>implementing a section on investigations for middle management and up. 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</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and investigation records was conducted on 10/28/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 8/6/14...Date of Knowledge: 8/7/14...Submitted Date: 8/8/14 involving client E indicated: "[Client E] was loaded onto the Van (sic) to go home from [Day Program]. [Client E] opened the door while it was in motion. [Client E] had his seat belt on. Staff came to a stop and he closed the door. He did this a few more times, he never took his seat belt (sic). Staff told him that was not safe and he needed to quit opening the door. [Client E] stated 'I don't care, just let me fall out and get ran over.' Staff would stop the van each time he opened the door to assure the safety. It is only a 2 mile drive from [Day Program] to the house. [Client E] was not injured due to opening the door. [Client E]'s IDT (Inter Disciplinary Team) members will discuss whether he can continue to sit in the front by the door or for his safety he needs to be in the back by the window or in the middle." Further review of the report failed to indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 8/15/14 involving clients A, B, C, D, E and F indicated: Text was received by [Staff name] at</p>		<p>an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>approximately 4:55 A.M., with allegations that [Staff #30] was doing drugs. Staff meeting was set for 8/15/14 at 10:00 A.M.. When [Staff #30] arrived for staff meeting she was escorted by [Nurse] to [Center] under an observed drug screen....[Staff #30] urine was sent to lab and came back positive. Staff was terminated." Review of the record failed to indicate the incident was investigated.</p> <p>-BDDS report dated 8/24/14 involving client F indicated: "Reported by staff that [client F] had 2 bruises on her inner right leg. They are injuries of unknown origin and will be investigated." Further review of the record failed to indicate the injuries of unknown origin were investigated.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/28/14 at 3:50 P.M.. When asked if there was documentation to indicate investigations were conducted in regards to the mentioned incidents, the QIDP indicated there was not any documentation.</p> <p>3. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 10/28/14 at 12:30 P.M.. Review of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>the records indicated:</p> <p>-BDDS report dated 7/15/14 involving client C indicated: "[Client C] was in workshop and walked into an office where staff was cleaning her office area and had a container of spoiled lasagna. [Client C] was noted to have food on his face when he walked out of the office that was being cleaned. Staff noted the lasagna was partially ate (sic)."</p> <p>-BDDS report dated 8/14/14 involving client C indicated: [Client C] consumed a small amount of [Dish soap] that was in a cup at the home."</p> <p>A review of client C's record was conducted on 10/28/14 at 4:50 P.M.. Review of his Behavior Support Plan dated 9/17/13 indicated: "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 C] on a more restrictive Watchful Eye Protocol. [Client C] should be in staff's LINE OF SIGHT AT ALL TIMES. The only exception to this is when [client C] is in the bathroom or bedroom; staff should ensure that he is in one of these locations initially and then</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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 C] is in the backyard, staff should be outside with him to ensure that he has not left the area through the fence."</p> <p>A review of the facility's abuse and neglect policy dated 12/12 was conducted on 10/29/14 at 7:30 P.M.. Review of the policy indicated:</p> <p>"Abilities Services, Inc. Abuse, Neglect, and Exploitation" dated 12/12 indicated: "It is the policy of Abilities Services, Inc. to protect and advocate for the protection and safety of all consumers in accordance with all applicable federal, state, and local laws. Abilities Services also sets forth procedures for staff to report all incidents or suspected incidents of abuse, neglect, exploitation, and violation of rights in accordance with all applicable rules, regulation, and laws. All staff of Abilities Services, Inc, are MANDATORY REPORTERS of observed or suspected abuse, neglect, and exploitation. Definitions: Verbal Abuse: Any yelling, cursing, screaming,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>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 punishment....It is a priority to notify immediately if actual or suspected Abuse, Neglect, or Exploitation occurs...Resident Elopement: a cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 11/3/14 at 2:20 P.M.. The QIDP indicated staff should follow the facility's abuse/neglect policy. When asked if the facility's policy was implemented in regards to the mentioned BDDS reports and investigations, the QIDP indicated the policy was not implemented. The QIDP indicated all incidents of abuse and neglect are to be immediately reported to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000153	<p>the administrator and within 24 hours to BDDS. The QIDP indicated the staff involved in the 7/27/14 incident received disciplinary action. The QIDP indicated all incidents of abuse and neglect are to be investigated.</p> <p>This federal tag relates to complaint #IN00157853.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 2 additional clients (clients E and F), to report an allegation of suspected abuse/neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 10/28/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-Investigation dated 5/19/14 involving clients D and F indicated: "It was reported that [Client D] had red Mark's (sic) on his back the evening of 5/19/14. The red marks were suspicious in nature. The agency nurse asked [client D] how he got the red marks on his back and he stated that [Staff #17] hit him. During investigation of the injury, [Staff #17] was accused of verbally abusing [client F] by multiple staff. The allegation that [client F] was verbally abused by [Staff #17] was not reported on 5/18/14. The allegation of verbal abuse was</p>	W000153	In response to W153, the facility failed for 2 additional clients to report an allegation of suspected abuse/neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services, 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 so an investigation can be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. The IR's are sent to the PD at the same time they are scanned to the others and the PD is notified by text of all IR's. The safety committee is following up weekly on any BDDS reportable incidents	12/01/2014			

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  11/07/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>investigated with the physical abuse....Investigation for verbal abuse by [Staff #17]-abuse was substantiated. Multiple witnesses. There was also an allegation of physical abuse that could not be substantiated but seemed likely to have occurred based on time frame and reporting. Termination was recommended and happened on May 23rd. Multiple accusations of stealing food from the company. Witness of her eating food on each shift. Had already received disciplinary action for sleeping."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 11/3/14 at 2:20 P.M.. The QIDP indicated this allegation of physical abuse was not immediately reported to the administrator or BDDS. The QIDP further indicated the allegation should have been immediately reported to the administrator and within 24 hours to BDDS.</p> <p>This federal tag relates to complaint #IN00157853.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for an injury of unknown origin and an allegation of abuse/neglect, involving 3 of 3 sampled clients and 2 additional clients (clients A, B, C, D, E and F), the facility failed to provide written evidence investigations were conducted.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 10/28/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 8/15/14 involving clients A, B, C, D, E and F indicated: Text was received by [Staff name] at approximately 4:55 A.M., with allegations that [Staff #30] was doing drugs. Staff meeting was set for 8/15/14 at 10:00 A.M.. When [Staff #30] arrived</p>	W000154	<p>In regard to ensuring the facility implemented its written policy and procedures to prevent abuse/neglect/exploitation, and to conduct thorough investigations of abuse/neglect, The system failed in the instances cited in this W for a few reasons:</p> <p>1. Confusion as to exact incidents needing investigated in consumer to consumer abuse and injuries of unknown origin 2. Thorough review of investigation once completed. 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 Director, 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</p>	12/01/2014

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>for staff meeting she was escorted by [Nurse] to [Center] under an observed drug screen....[Staff #30] urine was sent to lab and came back positive. Staff was terminated." Review of the record failed to indicate the allegation was investigated.</p> <p>-BDDS report dated 8/24/14 involving client F indicated: "Reported by staff that [client F] had 2 bruises on her inner right leg. They are injuries of unknown origin and will be investigated." Further review of the record failed to indicate the injuries of unknown origin were investigated.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/28/14 at 3:50 P.M.. When asked if there was documentation to indicate investigations were conducted in regards to the mentioned incidents, the QIDP indicated there was not any documentation.</p> <p>This federal tag relates to complaint #IN00157853.</p> <p>9-3-2(a)</p>		<p>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 guidelines for investigations, to ensure investigations are completed. 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</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients and 3 additional clients (clients A, B, C, D, E and F), to ensure staff were sufficiently trained to 1. assure competence in proper administration of medications as ordered, 2. following client A's "G-Tube High Risk Plan." and 3. following client C's line of sight protocol.</p> <p>Findings include:</p> <p>1. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 10/28/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 5/25/14 involving</p>	W000189	<p>consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p> <p>In response to w189, the facility failed to ensure staff were sufficiently trained to 1. assure competence in proper administration of medications as ordered, 2. following client A's "G-Tube High Risk Plan." and 3. following client C's line of sight protocol. All training files have been reviewed. All specific consumer training is completed upon hire, as changes are made, and annually. Staff has been retrained as part of the poc. The nurse, QIDP, and PC are on a weekly scheduled rotation to observe staff in the group home setting following plans and medication passes. Any issues noted will be reviewed in weekly safety meetings. All training files are maintained by the records coordinator and notices are sent for anyone missing a training and there is a specific time period to complete the training before</p>	12/01/2014

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>client F indicated: "Consumer was home with family for the weekend upon return noted 1 tablet was not given of scheduled med. This was found upon return and staff signing in medication." Further review of the record did not indicate which medication was not given.</p> <p>-BDDS report dated 6/20/14...Date of Knowledge: 7/14/14...Submitted Date: 7/14/14 involving client F indicated: "Staff was sweeping kitchen floor and found a Docusate (stool softener pill) on the floor. Staff was unaware who's (sic) pill it was although only [client E] and one other consumer in the house take Docusate. It is also undetermined when the medication was missed due to the pill being found on the floor. All staff are trained through Medcore and must have three observed medication passes before they can pass medications. All staff are trained that medications should be passed only in the medication room. Staff should assure all medications have been swallowed before consumer is allowed to leave medication room, this is to assure all medication (sic) are taken properly." Further review of the report indicated the other client was client D.</p> <p>-BDDS report dated 6/29/14 involving client F indicated: "[Client F] went home on Friday 6/27/14 after [Day Program]."</p>		they are removed from the work schedule.				

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>While at home he did not receive 2 doses of Tizanadine (sic) (muscle spasms)."</p> <p>-BDDS report dated 7/11/14...Date of Knowledge: 7/17/14...Submitted Date: 7/18/14 involving client F indicated: "Night shift was passing [client F] his antibiotic Levaquin and noticed there was an extra pill. After investigation it was discovered that [Staff #20] did not pass [client F]'s levaquin on 7/1/14 at 8:30 A.M....[Staff #20] will receive disciplinary action per ASI policy."</p> <p>-Investigation dated 7/27/14 noted involving clients A, B, C, D, E and F indicated: "Describe any injuries or right violations that are alleged: Neglect...On 7/27/14 upon arriving to work at 8:50 A.M., [Staff #13] stated that she could not get anyone to answer the door and when [Staff #14] and [Staff #15] did finally answer the door, it was apparent that they had been asleep. Meds were not passed, consumers were still in bed....Summary of Findings: [Staff #14 and #5] had to have been sleeping. [Staff #15] admits to it, [Staff #14] does not....Conclusion: Substantiated." Review of the record indicated clients A, B, C, D, E and F did not get their morning medications.</p> <p>-BDDS report dated 7/28/14...Date of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Knowledge: 7/30/14...Submitted Date: 7/30/14 involving client E indicated: "While staff was passing medications on 7/29 they noticed that a pill was not popped for DOK for 7/28 for [client E]. Staff will receive disciplinary action per ASI policy."</p> <p>-BDDS report dated 7/30/14 involving client F indicated: "[Client F] brought out a pill to staff that he found in his bedroom. Staff determined the pill was Tylenol, this is a PRN (as needed) medication for [client F]. The two times he was administered the medication on 7/19 and 7/13 he did not complain he did not receive the medication. It is unclear which date the pill was dropped."</p> <p>-BDDS report dated 8/31/14 involving client F indicated: "[Client F] was home with Parents 8/29/14 thru 8/31/14. Meds were sent home during this time. Upon return and checking meds in [Staff #21] noted that 1 8 P.M. tablet of the correct dose of Carbamazepine (seizures) was missed. He received 1 pill instead of 2. Continue with family education at the time of pick up."</p> <p>-BDDS report dated 9/1/14...Date of Knowledge: 9/3/14...Submitted Date: 9/3/14 involving client E indicated: "[Client E] started a new med Oyster Cal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>+ D 500 mg (milligrams)-400 tab (supplement) 3 tabs by mouth daily. This order started 9/1/14. [Staff #25] passed 9/1/14 dose and only administered 1 tablet. [Staff #25] will be submitted for disciplinary action."</p> <p>-BDDS report dated 9/2/14 involving client E indicated: "[Client E] started a new med Oyster Cal + D-400 tab 3 tabs by mouth daily. This order started on 9/1/14. [Staff #26] passed 9/2/14 dose and only administered 1 tablet...[Staff #26] will be submitted for disciplinary action."</p> <p>-BDDS report dated 9/10/14...Date of knowledge: 9/11/14...Submitted Date: 9/12/14 involving client F indicated: "[Client F] received Carbamazepine 1 tab on 9/10/14 instead of the order 2 tabs.... [Staff #22] and [Staff #23] was assigned to med pass. [Staff #22] and [Staff #23] will be submitted for disciplinary action."</p> <p>-BDDS report dated 10/5/14 involving client E indicated: "[Client E] did not receive her medication Omeprazole (Gastroesophageal Reflux Disease) and Calcium Carb (supplement) the morning of 10/5/14. It was noted upon passing evening medications that the pack was not taken off the roll and administered. [Staff #28] will be submitted for</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>disciplinary action per policy."</p> <p>A review of the facility's "Medication Administration System" Dated 12/12 was conducted on 10/28/14 at 7:30 P.M. and indicated:</p> <p>"Purpose: To ensure medications (administration, destruction, errors) are handled in a safe, appropriate manner...To ensure the medical well being of the individuals served are met with the highest level of service possible, Abilities Services, Inc. employees are trained annually and capable of handling a variety of medication situations...The individual administering the medication will initial completion of each dose given on the MAR and the bubble pack after the medication has been administered as trained."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff are trained on the facility's medication administration upon hire and then annually. The QIDP indicated staff should pass medications as ordered by the physician and further indicated staff should follow the policy at all times. The QIDP indicated staff should have checked the label three times prior to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>dispensing the medications to prevent medication errors. The QIDP further indicated the agency's nurse retrains staff after medication errors occur.</p> <p>2. An evening observation was conducted at the group home on 10/29/14 between 4:00 P.M. and 5:00 P.M.. At 4:15 P.M., DSP #4 began administering client A's medications and feeding client A via his G tube (feeding tube) as he sat in his wheelchair. Client A was not laying down. DSP #4 did not line black marks together. DSP #4 did not pull on the tube lightly and there was no stomach acid in the tubing. DSP #4 did not disconnect and start over.</p> <p>A review of client A's record was conducted on 10/28/14 at 3:30 P.M.. A review of client A's 'G-tube High Risk Plan' dated 8/7/13 indicated: "[Client A] has a Mickey-tube that his medications are crushed and administered through as well as his daily nutrient/formula. [Client A] does not consumer (sic) anything through his mouth. He does not receive any feeding while at Day Services but staff does administer his formula when he has respite. The following are the instructions to administer formula through his g-Mickey tube:</p> <p>[Client A] is to be laying down.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1. Connect the plunger to the tube before attaching to [client A].</p> <p>2. Line up black on the button attached to [client A] and the tube.</p> <p>3. Turn clockwise 1/2 to 3/4 of the way around.</p> <p>4. Pull on tube lightly to ensure it is in. You will see stomach acid in tubing if done correctly. If the stomach acid is not seen the staff needs to disconnect tube and start at step 2 again.</p> <p>5. Put the correct number of ounces in the syringe. Once the formula is almost gone add the predetermined amount of water.</p> <p>6. Turn to match black lines up on button and tube then remove."</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDP) was conducted on 11/3/14 at 2:20 P.M.. The QIDP indicated staff should follow client A's G-tube protocol at all times. The QIDP further indicated all staff who work at the group home had been trained by the agency's nurse on client A's G-tube protocol.</p> <p>3. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>on 10/28/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 7/15/14 involving client C indicated: "[Client C] was in workshop and walked into an office where staff was cleaning her office area and had a container of spoiled lasagna. [Client C] was noted to have food on his face when he walked out of the office that was being cleaned. Staff noted the lasagna was partially ate (sic)."</p> <p>-BDDS report dated 8/14/14 involving client C indicated: [Client C] consumed a small amount of [Dish soap name] that was in a cup at the home."</p> <p>A review of client C's record was conducted on 10/28/14 at 4:50 P.M.. Review of his Behavior Support Plan dated 9/17/13 indicated: "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 C] on a more restrictive Watchful Eye Protocol. [Client C] should be in staff's LINE OF SIGHT AT ALL TIMES. The only exception to this is when [client C] is in the bathroom or bedroom; staff should ensure that he is in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>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 C] is in the backyard, staff should be outside with him to ensure that he has not left the area through the fence."</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDP) was conducted on 11/3/14 at 2:20 P.M.. The QIDP indicated staff should follow client C's line of sight protocol at all times. The QIDP further indicated all staff working at the group home have been trained on C's protocol.</p> <p>This federal tag relates to complaint #IN00157853.</p> <p>9-3-3(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to assure drugs administered to 3 of 3 sampled clients and 3 additional clients (clients A, B, C, D, E and F) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 10/28/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-Investigation dated 7/27/14 noted involving clients A, B, C, D, E and F indicated: "Describe any injuries or right violations that are alleged: Neglect...On 7/27/14 upon arriving to work at 8:50 A.M., [Staff #13] stated that she could not get anyone to answer the door and when [Staff #14] and [Staff #15] did</p>	W000368	In response to W368, the agency failed to assure medications administered were in compliance with the physician's orders, the facility nurse has reviewed all client's MAR to ensure instructions are clear and that any issues with administration are identified and the doctor contacted For future issues, the newly contracted pharmacy will note any potential issues with administration of medications during quarterly reviews On a monthly basis, the MAR will also be reviewed by the contracted RN as a additional check to the agency Nurse Any noted issues will be documented in nursing notes and handled accordingly Random monthly med evaluations are conducted to decrease med errors Additionally, ASI has policy for med errors that includes retraining and disciplinary action Upon consumers being gone, ASI nurse will review meds with the family before leaving ASI nurse will review meds with the	12/01/2014

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>finally answer the door, it was apparent that they had been asleep. Meds were not passed, consumers were still in bed....Summary of Findings: [Staff #14 and #5] had to have been sleeping. [Staff #15] admits to it, [Staff #14] does not....Conclusion: Substantiated."</p> <p>Review of the record indicated clients A, B, C, D, E and F did not get their morning medications.</p> <p>-BDDS report dated 5/25/14 involving client F indicated: "Consumer was home with family for the weekend upon return noted 1 tablet was not given of scheduled med. This was found upon return and staff signing in medication." Further review of the record did not indicate which medication was not given.</p> <p>-BDDS report dated 7/11/14...Date of Knowledge: 7/17/14...Submitted Date: 7/18/14 involving client F indicated: "Night shift was passing [client F] his antibiotic Levaquin and noticed there was an extra pill. After investigation it was discovered that [Staff #20] did not pass [client F]'s levaquin on 7/1/14 at 8:30 A.M....[Staff #20] will receive disciplinary action per ASI policy."</p> <p>-BDDS report dated 6/20/14...Date of Knowledge: 7/14/14...Submitted Date: 7/14/14 involving client F indicated:</p>		family before leaving The agency nurse is also conducting weekly med pass evals at the group home All med errors are reviewed weekly in safety committee				

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>"Staff was sweeping kitchen floor and found a Docusate (stool softener pill) on the floor. Staff was unaware who's (sic) pill it was although only [client E] and one other consumer in the house take Docusate. It is also undetermined when the medication was missed due to the pill being found on the floor. All staff are trained through Medcore and must have three observed medication passes before they can pass medications. All staff are trained that medications should be passed only in the medication room. Staff should assure all medications have been swallowed before consumer is allowed to leave medication room, this is to assure all medication (sic) are taken properly." Further review of the report indicated the other client was client D.</p> <p>-BDDS report dated 6/29/14 involving client F indicated: "[Client F] went home on Friday 6/27/14 after [Day Program]. While at home he did not receive 2 doses of Tizanadine (sic) (muscle spasms)."</p> <p>-BDDS report dated 7/25/14...Date of Knowledge: 7/27/14...Submitted Date: 7/27/14 involving client C indicated: "[Client C] went home with his parents on Friday 7/25/14 all his medications were sent home with him. When he returned on Sunday 7/27/14 staff notified Residential nurse around 4 P.M. that he</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>did not receive his folic acid on 7/25/14 at 8:00 P.M.....Family will be educated on the importance of giving all medications while at home."</p> <p>-BDDS report dated 7/28/14...Date of Knowledge: 7/30/14...Submitted Date: 7/30/14 involving client E indicated: "While staff was passing medications on 7/29 they noticed that a pill was not popped for DOK for 7/28 for [client E]. Staff will receive disciplinary action per ASI policy."</p> <p>-BDDS report dated 7/30/14 involving client F indicated: "[Client F] brought out a pill to staff that he found in his bedroom. Staff determined the pill was Tylenol, this is a PRN (as needed) medication for [client F]. The two times he was administered the medication on 7/19 and 7/13 he did not complain he did not receive the medication. It is unclear which date the pill was dropped."</p> <p>-BDDS report dated 8/31/14 involving client F indicated: "[Client F] was home with Parents 8/29/14 thru 8/31/14. Meds were sent home during this time. Upon return and checking meds in [Staff #21] noted that 1 8 P.M. tablet of the correct dose of Carbamazepine (seizures) was missed. He received 1 pill instead of 2. Continue with family education at the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>time of pick up."</p> <p>-BDDS report dated 9/1/14...Date of Knowledge: 9/3/14...Submitted Date: 9/3/14 involving client E indicated: "[Client E] started a new med Oyster Cal + D 500 mg (milligrams)-400 tab (supplement) 3 tabs by mouth daily. This order started 9/1/14. [Staff #25] passed 9/1/14 dose and only administered 1 tablet. [Staff #25] will be submitted for disciplinary action."</p> <p>-BDDS report dated 9/2/14 involving client E indicated: "[Client E] started a new med Oyster Cal + D-400 tab 3 tabs by mouth daily. This order started on 9/1/14. [Staff #26] passed 9/2/14 dose and only administered 1 tablet...[Staff #26] will be submitted for disciplinary action."</p> <p>-BDDS report dated 9/10/14...Date of knowledge: 9/11/14...Submitted Date: 9/12/14 involving client F indicated: "[Client F] received Carbamazepine 1 tab on 9/10/14 instead of the order 2 tabs.... [Staff #22] and [Staff #23] was assigned to med pass. [Staff #22] and [Staff #23] will be submitted for disciplinary action."</p> <p>-BDDS report dated 10/5/14 involving client E indicated: "[Client E] did not receive her medication Omeprazole</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(Gastroesophageal Reflux Disease) and Calcium Carb (supplement) the morning of 10/5/14. It was noted upon passing evening medications that the pack was not taken off the roll and administered. [Staff #28] will be submitted for disciplinary action per policy."</p> <p>A review of the facility's "Medication Administration System" Dated 12/12 was conducted on 10/28/14 at 7:30 P.M. and indicated:</p> <p>"Purpose: To ensure medications (administration, destruction, errors) are handled in a safe, appropriate manner...To ensure the medical well being of the individuals served are met with the highest level of service possible, Abilities Services, Inc. employees are trained annually and capable of handling a variety of medication situations....The individual administering the medication will initial completion of each dose given on the MAR and the bubble pack after the medication has been administered as trained."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional Designee (PD/QIDP) was conducted on 11/3/14 at 2:20 P.M.. The PD/QIDP indicated staff should have checked the label three times</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>prior to dispensing the medications to prevent medication errors. The PD/QIDP further indicated staff should have followed the facility's medication administration policy.</p> <p>This federal tag relates to complaint #IN00157853.</p> <p>9-3-6(a)</p>						
W000436	<p>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 observation, record review, and interview, for 1 of 3 sampled clients who used adaptive aids and devices (client A), the facility failed to encourage and teach the use of his eyeglasses.</p>	W000436	<p>In response to W436, the facility failed to encourage and teach the use of wearing eyeglasses. Consumer protocol for wearing eyeglasses has been updated and staff has been retrained.</p>	12/01/2014			

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings include:</p> <p>A facility owned day program observation was conducted on 10/29/14 between 1:20 P.M. and 2:30 P.M.. During the entire observation, client A sat in his wheelchair. Client A did not wear his eyeglasses. Direct Support Professional (DSP) #1 and #2 did not prompt client A to wear his eyeglasses.</p> <p>An evening observation was conducted at the group home on 10/29/14 between 4:00 P.M. and 5:00 P.M.. At 4:00 P.M., client A arrived at the group home. During the entire observation, client A did not wear his eyeglasses. DSP #4, #5 and #6 did not prompt client A to wear his eyeglasses.</p> <p>A review of client A's record was conducted on 10/28/14 at 3:30 P.M.. A review of client A's Individual Support Plan (ISP) dated 6/24/2014 indicated: "[Client A] wears glasses during the day. He has astigmatism. He is not able to clean them himself, he requires someone to clean them. He needs to have them placed on him but, he can take them off by himself."</p> <p>The Qualified Intellectual Disabilities</p>		<p>Additionally, the Nurse, QIDP and PC will ensure at weekly site checks that protocol is being followed. There was confusion for staff between training and guardian instruction. This has been resolved.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W009999	<p>Professional (QIDP) was interviewed on 11/3/14 at 2:20 P.M.. The QIDP indicated staff should be teaching clients to wear their adaptive equipment at all times. The QIDP further indicated staff should have prompted client A to wear his eyeglasses.</p> <p>This federal tag relates to complaint #IN00157853.</p> <p>9-3-7(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p>	W009999	In response to W9999, the facility failed to report a med error to BDDS in a timely manner, the facility has reviewed records for any late filings All BDDS will be reviewed by the Programming Director to ensure that filings take place in the required amount of time All staff filing BDDS reports have been re-notified that the reporting guidelines A plan for absences and time off will be established to cover filings in case of a nurse or QIDP being out	12/01/2014			

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  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 1 fall with injury, involving 1 additional client (client F), to report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Internal Incident reports and investigations was conducted on 10/28/14 at 12:30 P.M. and indicated:</p> <p>-BDDS report dated 7/26/14...Date of Knowledge: 7/28/14...Submitted Date: 7/28/14 involving client F indicated: "While staff was loading [client F] into the van she caught her foot on the lip of the step into the van. She fell to her knees. Staff helped her up and when they got her into the van they checked her and noticed two red marks with small scrapes on her shins from where they hit the step." Further review failed to indicate this fall with injury was immediately reported to the administrator and BDDS.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2014	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1, 2011 was conducted on 10/29/14 at 5:50 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS... Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in of having the potential to result in significant harm or injury to an individual including but not limited to: -"Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>15. A fall resulting with injury, regardless of the severity of the injury."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/3/14 at 2:20 P.M.. The QIDP indicated the fall with injury was not immediately reported to BDDS. The QIDP further indicated the fall with injury should have been reported to BDDS within 24 hours to BDDS.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/07/2014
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	9-3-1(b)				